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Transgender EuroStudy:

Legal Survey and Focus on the Transgender Experience of Health Care

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Foreword

This research project, commissioned by ILGA-Europe, follows a similar large scale study we conducted in the UK in 2006.[1] During July 2007 and December 2007 the researchers undertook a mixed quantitative/qualitative approach to collecting and analysing information on transgender and transsexual people's experiences of inequality and discrimination in accessing healthcare in Europe. This was a large undertaking given the timescale; even more so as we had to recruit translators from 13 different countries as well as conduct focus groups and get translations done. This report is an analysis and summary of the results obtained and it details the barriers that trans people face when accessing healthcare.

The work undertaken is certainly the largest and most comprehensive data collection on trans people's lived experience to date. One can never claim that research data is entirely representative of a community; even less so when the community being studied consists of many small sub-communities as is the case with trans people. However, as will be detailed in the data analysis section of this report, the statistics we have on the profile of respondents do generally match data of the population of Europe (for example the percentage of those with a disability). Other statistics that do not match the European population (for example educational attainment) are consistent with the large scale study of trans people in the UK – hence it could be argued that these features may be anomalous to trans people. We are confident then, that the size and quality of our sample of the population is sufficient to draw upon for our claims and that the experiences of trans people accessing healthcare detailed in this report are credible.

[1] Whittle, Turner and Al-Ami Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination 2007.

Executive Summary

The Legal Survey

The legal survey confirmed that very few countries had fully embraced the range of transgender protections available in Europe. Some have made very little progress, leaving their trans citizens in fear for their safety, unable to work due to discrimination, and facing great difficulties in obtaining access to gender reassignment services.

The failure of States to implement directives and significant case law, from both the ECJ and the ECHR, has left a Europe divided with a few of its trans population having fairly good access to medicine and their rights, but even then no country is by any means perfect. The UK does better than most States but this must partly be due to the volume of cases brought by trans people in the UK. There seems to be a dearth of such individuals elsewhere in Europe.

Recommendations are that:

- The European Commission as guardian of the treaties should ensure that EU directives on equal treatment of women and men and gender equality are implemented to include protection of trans people against discrimination.
- Legal action based on EU directives needs to be revisited to ensure accessibility for ordinary people in a manner which is quick and at minimum cost, particularly when Member States have not implemented EU directives. [2]
- Funding is needed to ensure that trans people throughout Europe are made aware of their rights contained in the EU directives and the European Convention on Human Rights.
- States need to provide gender reassignment treatment without excessive restrictions.

Methodology

The analysis for this report focuses on 615 (female to male) trans men, and 1349 (male to female) trans women, who were the survey respondents as of 1 December 2007 after incomplete or duplicate responses were removed.

In total, the focus group respondents were 12 trans men, 24 trans women and one non-gendered person.

We devised an Acceptable Baseline (AB) system for the analysis of survey responses. This was the bare minimum standard of treatment that trans people should expect to receive in terms of: clinical need and acceptable treatment of patients by health care professionals. This was then compared across the experiences of respondents who belonged to different categories:

- Respondents who transitioned less than 5 years ago compared with those who transitioned more than 10 years ago.
- Respondents who earned less than €20,000 per year compared with those who earned more than €50,000 per year.
- Respondents who were in skilled occupations compared with those who were in unskilled occupations.

Clinical Need Met

State funding for hormones

The majority of respondents were refused State funding for hormones – more than 79% consistently across all the different categories, with a maximum of 5% difference between each group category.

State funding for surgery

More than 82% of respondents of all the categories were refused State funding for the acceptable baseline surgeries – these were the minimum required for trans people to live in their acquired gender. There was only a maximum of 6% difference in figures across the group categories.

[2] Francovich v Republic of Italy ECJ (1995) ICR 722, ECJ Cases C-6 and 9/90 (also reported at [1992] IRLR 84 and [1993] 2 CMLR 66).

Refused treatment because a healthcare practitioner did not approve of gender reassignment

More than 25% of the respondents from all the selected groups reported that they were refused treatment because a practitioner did not approve of gender reassignment. Those on higher incomes had a markedly lower reporting rate of refusal than those on lower incomes.

Refused treatment and paid themselves

A minimum of 51% of respondents paid for their treatment after funding refusal. There was minimal difference across the group categories. Nearly half of all respondents were in the lower income bracket of less than €25,000 per year.

Treatment by Healthcare Professionals

Responses by healthcare professionals when treatment was requested

A maximum of only 30% of respondents across the group categories reported experiencing this acceptable baseline – a practitioner wanting to help but lacking information about trans issues.

Experiences accessing non trans-related healthcare

A minimum of 15% and a maximum of 23% of respondents felt that being trans affected the ways that they accessed routine non trans-related healthcare. There was a slight difference between the category groups.

This was supported by the narratives from the qualitative data which suggested that trans people avoided accessing routine healthcare because they anticipated prejudicial treatment from healthcare professionals.

How being trans impacted treatment by healthcare professionals

A minimum of 18% and a maximum of 31% felt that being trans impacted how they were treated by healthcare professionals. There was a slight improvement for those who transitioned more recently and those in skilled occupations.

This section of research was the most supported by narratives in the qualitative research. The most consistent theme was that of improper or abusive treatment by healthcare professionals.

Conclusion

The data from this research shows that, regardless of earnings and social status, the healthcare treatment for trans people currently being provided in their countries is very poor.

- In terms of clinical need, a high majority of respondents are not getting State funding for hormones and primary baseline surgeries.
- Nearly one third were refused treatment because a healthcare practitioner did not approve of gender reassignment.
- More than half of the groups at both ends of our occupational and earnings spectrum are paying for surgery themselves after being refused State funding. Given that nearly half of all respondents are in the lower income bracket of less than €25,000 per year this is an onerous and unnecessary financial burden.

It is significant that the narratives from the qualitative data found that trans people avoid accessing routine healthcare because they anticipate prejudicial treatment from healthcare professionals.

There is also strong evidence from the focus group and survey data that the link between seeking gender reassignment and mental illness is a strong factor in the (mis)treatment of trans people. The qualitative data documents abusive and improper treatment of trans people by healthcare professionals.

The Growth in the Trans Population

The data from the survey for this report provides strong evidence that the trans population is growing exponentially year-on-year. The majority of respondents reported that they had transitioned less than 5 years ago. This clearly has implications for the provision of trans-related healthcare in the immediate future, and is a prompt to action now.

The Issues Facing Trans People Accessing Healthcare

- The current shortage of accessible, localised, access to specialist care for transgender and transsexual people.
- Current service provision, even if accessible, generally provides a very poor experience for the trans person.
- Many current service providers need to take action so as to provide a regularized service that meets internationally recognised best practice (WPATH, 2001).
- The issue of the rights of trans people to dignity in healthcare.

Introduction

In this report we refer to people who may identify as transgender, transsexual or gender variant in any way as 'trans'. This is because the population of people who identify as a different gender to that assigned at birth is very diverse. Members are particular about the terms that they wish to be addressed by, thus trans is an easy, inclusive shorthand. The term trans is not ideal, but is used to embrace those who cross (or have crossed) the conventional boundaries of gender; in clothing; in presenting themselves; even as far as having multiple surgical procedures to be fully bodily reassigned in their preferred gender role. Trans has become the term of normal use since the coining of it by Press for Change for their 1996 mission statement: "seeking respect and equality for all trans people".

How Many Trans People are There?

There has been much speculation estimating the number of transgender and transsexual people and the conclusion is that there is simply no publicly available statistical data on which to make a firm statement. Estimates range from about 1 in 11,000 to as many as 1 in 20 in the male population and the ratio between those assigned male at birth seeking gender reassignment and those assigned female, is estimated at 3:1 (van Kesteren et al 1996). One of the problems is the criteria by which the population is measured – those who have had surgery? Those who are on hormone replacement therapy? What about trans people who do not seek medical diagnosis and treatment? What we can claim is that the evidence from this report strongly suggests that the trans population is growing exponentially and the ratios between those assigned male and female at birth are probably as near as 1:1. This is explored in more detail in this report.

In this research project we have endeavoured to be as inclusive as possible of different 'types' of trans-identified people. However, the members of the population who seek to be reassigned[3] to their preferred gender are the most apposite to this report as the process of undergoing gender reassignment involves frequent contact with health service professionals. Indeed, a trans person has to be 'diagnosed' as transsexual by health practitioners in order to gain access to gender reassignment treatment. Although trans people have recently been included with the Lesbian, Gay and Bisexual (LGB) population routinely in policy and research on 'LGBT' healthcare, there are differences between the groups.

The Medicalisation of Trans

The most significant issue is that trans people (who wish to undergo gender reassignment) have to gain access to medical treatment in order to realise their identities. This places trans people in a position with healthcare providers which has all the hallmarks of a difficult relationship: power and control; desire and need coupled with vulnerability; pathologisation and protocol. The findings of this report document the consequences of this problematic configuration.

Further, transsexualism is classified as a mental disorder. This is found in the Diagnostic and Statistical Manual (DSM) IV for the American Psychiatric Association (APA); the International Classification of Diseases and the World Health Organisation (WHO), although it is acknowledged that the symptoms improve with hormone treatment and surgery. The location of transsexualism in the category of mental disorder further mars the relationship between trans patients and practitioners, as the qualitative findings of this report illustrate.

[3] Gender reassignment refers in an indirect way to the fact that every person has their gender 'assigned' at birth – usually by a cursory glance at the genitals to see if there is a presence or absence of a penis. To have one's gender 'reassigned' means undergoing a legal or judicial process where the State formally recognises one's 'new' gender. In many European States this process is only possible after bodily reassignment by surgery.

Recent Developments in the Trans Community

The last 15 years have seen a major change in the trans community. The growth of home computer use in the 1990s and the encouragement of many trans women at the forefront of information technology and internet development were to be crucial in the development of a new, geographically spread, but no longer isolated trans community (Whittle 1998). More recently, it has become a community with an understanding and an awareness of common experiences, through the use of the internet, email lists and websites, and the increasing media coverage of trans stories. The trans community is still relatively 'young' in that the 'first generation' underwent gender reassignment in the 60s, 70s and 80s. Moreover, the political, legal and social landscape was very different then and is continuing to change.

Like the 'coming out' of gay people in the early gay liberation movement, trans people over the last 15 years have become politicised through new communication technology – particularly in the UK and the US, and are more visible in public positions – for example in academia and politics. Up until recently, trans people post gender transition were required to 'disappear' – to become ostensibly 'post transsexuals' (Stone 1991). This report found that the 'disappearance' of trans people post transition continues to be the norm in some European States, making it difficult to locate trans people to participate in this research. If all trans people in Europe had become 'non-trans people' and 'disappeared', we would have had no participants. We are glad that this was not the case and we managed to find networks of trans people who could be contacted as with no participants there is no research.

The research in this report demonstrates that trans people are consistently denied access to even the most basic medical treatment required to enable them to live in their preferred gender role. They are medicalised, they are subsumed into the category of mentally ill, they are humiliated by medical practitioners and they are denied access to non trans-related care because they are trans.

It is clear that the bodies of the European Union, and in particular the European Commission, cannot dictate to Member States how to organise or adminster their healthcare systems; it is equally true that the European Commission is in the position to highlight the rights of trans to equal treatment in accordance with directives and case law on this point. By acting promptly in accordance with the recommendations contained in this report, the European Commission and other concerned bodies could ensure a European wide shift in attitudes and practice towards trans people.

Trans people have the same rights as everyone else to adequate, respectful and accessible healthcare; the shame they are forced to undergo for even the most basic medical treatment offends against basic principles of equality and human rights. There can be no doubt that prompt action is needed, and is possible, the only doubt is whether that action will be taken.

Transgender and Transsexual Legal Concerns in Europe

An Overview: EU Anti-discrimination Legislation

In recent years the European Court of Justice[4] (ECJ), the Court of Human Rights[5] (ECHR), and recent directives have afforded some very specific legal rights to trans people.

In the case of *P v S & Cornwall County Council* in 1996, the ECJ held that the Equal Treatment Directive (76/207/EEC)[6] provided protection against discrimination to trans people in employment. Asserted again in the pension cases *of K.B. and National Health Service Pensions Agency and Richards v Secretary of State for Work and Pensions, P v S* created the principle that European sex anti-discrimination legislation protects individuals on the basis of their gender role, not the sex given to them at birth.

This has been further confirmed by the *Directive on Equal Opportunities and Equal Treatment of Men and Women in Matters of Employment and Occupation* (2006/54/EC); and extended to include protection in goods and services by the *Directive on the Principle of Equal Treatment between Men and Women in the Access to and Supply of Goods and Services* (2004/113/EC). Though this directive itself does not mention trans people, protection to those "intending to undergo, undergoing or who have undergone gender reassignment" is implemented by a statement from the Joint Council and Commission in the minutes of the 2606th meeting of the Council of the European Union.[7] Member States were to implement this later directive into national law by 21 December 2007.

As yet it is not clear if any State has specifically included trans people in the implementation of the directives in national law.[8] However, in the case of *Mangold v Helm*[9], the ECJ stated that it:

> "is the responsibility of the national court to guarantee the full effectiveness of the general principle of non-discrimination in respect of (age), setting aside any provision of national law which may conflict with Community law, even where the period prescribed for transposition of that directive has not yet expired".[10]

So, in principle, this protection against discrimination in accessing goods and services should be in place for trans people since the publication of the Directive (2004/113/EC) in the European Official Journal in December 2004. Unfortunately, when most Legal Centres and NGOs were asked about the protection, very few knew enough about the law to advise people correctly, and trans people continued to believe they have no protection against discrimination in accessing goods and services. Most agencies felt uneasy about taking cases because they had no guidance from prior jurisprudence.

The Court Decisions: the ECHR

Cases brought before the ECHR concerned people who are known as transsexual because they undergo gender reassignment treatments. From the early case of *Van Oosterwijck v Belgium*[11] several of the cases brought were unsuccessful in advancing the rights of trans people. However, there was a small success in the case of *B v France*[12] when the Court held that:

[4] *P v S and Cornwall County Council* (Case C-13/94) [1996], IRLR 347; *K.B. and National Health Service Pensions Agency, Secretary of State for Health* (Case C-117/01) [2004]; and *Richards v Secretary of State for Work and Pensions* (Case C-423/04) [2006].

[5] Christine Goodwin v UK Government, Application No. 28957/95 ECHR, [2002]; I v UK Government, Application No. 25608/94 ECHR, [2002]; Grant v United Kingdom, Application No.32570/03 ECHR, [2006]; and L v Lithuania Application No. 27527/03 ECHR, [2007].

[6] Amended by Directive 2006/54/EC.

[7] Council of the European Union 2606th meeting of the Council of the European Union (Employment, Social Policy, Health and Consumer Affairs), held in Luxembourg on 4 October 2004.

[8] Though we do know the UK proposed regulations but these were withdrawn at the very last minute due to political problems.

[9] *Mangold v Helm* (Case C-144/04) ECJ [2005].

[10] Ibid para 79(2)

[11] Van Oosterwijck v Belgium (Application No. 3/1979/31/46) ECHR, [1980].

[12] B v France (Application no 57/1990/248/319), ECHR, [1982].

> "even having regard to the State's margin of appreciation, the fair balance which has to be struck between the general interest and the interests of the individual has not been attained, and there has thus been a violation of Article 8."[13]

As a consequence, France had to provide for the recognition of the change of gender on personal identity cards and official documents. Very few other countries followed, but this was the beginning of the Court recognising that privacy, concerning their gender reassignment, is crucial to the daily life of many trans people. Unfortunately, as a result, France also developed a very strict system whereby the change of gender on documents was only available to trans people who went through a very specific medical setting, leading to genital surgery and sterilisation. In 2007, 25 years later, trans people in France are still fighting to obtain the right to attend other clinics and not to have genital surgery and sterilisation in order to get the change on their official papers.

The string of failures before the ECHR continued through the 1980s and 90s, and it was not until the decisions in *Goodwin and I v United Kingdom*[14] in 2002 and the beginnings of a wider movement for change through Europe that there was any level of legal success. In Goodwin & I the Court considered its jurisprudence then proceeded to recognise that the ECHR protected the right to private life and the right to marry of transsexual people.

On Birth Certificates and other records, the Court said:

> "The United Kingdom national health service, in common with the vast majority of Contracting States, acknowledges the existence of the condition and provides or permits treatment, including irreversible surgery. The medical and surgical acts which in this case rendered the gender re-assignment possible were indeed carried out under the supervision of the national health authorities. Nor, given the numerous and painful interventions involved in such surgery and the level of commitment and conviction required to achieve a change in social gender role, can it be suggested that there is anything arbitrary or capricious in the decision taken by a person to undergo gender re-assignment. In those circumstances, the ongoing scientific and medical debate as to the exact causes of the condition is of diminished relevance."[15]

As such, it was held that because most European States allow proper medical practitioners and authorities to provide gender reassignment – which is known to be a very hard choice for the patient – any argument that it is a 'choice' or 'fancy' is no longer viable. It was also held that the medical debate on aetiology is of no great importance, i.e. the cause of transsexualism is not relevant to the law. The Court then said:

> "the unsatisfactory situation in which post-operative transsexuals live in an intermediate zone as not quite one gender or the other is no longer sustainable"[16]

thus condemning States leaving post-operative[17] transsexual people with a 'no-sex', 'intermediate sex' or 'both sex' legal status. The Court went on to say that "a test of congruent biological factors can no longer be decisive."[18] The Court held that the current position of affording treatment and then refusing a change of legal status was illogical.[19]

On the question of marriage, the Court held that it was contrived to assert that transsexual people had not been deprived of the right to marry because, in law, they could marry a person of their opposite birth sex.

[13] Ibid para 63.

[14] Supra at note 5.

[15] Goodwin Supra at note 5, para 81.

[16] I Supra at note 5, para 70.

[17] Nowhere is post-operative defined in the judgement.

[18] I, Supra at note 5, Para 81 once and for all putting aside the decision in the influential UK case of Corbett v Corbett, [1970] 2 All E.R. 33, 48.

[19] Goodwin Supra at note 5, para 79.

> " … In the Court's view, (they) may therefore claim that the very essence of (their) right to marry has been infringed."[20]

The Court further held that it is also an artifice to claim that although Article 12 secures the fundamental right of a man and woman to marry and to found a family, people do not have to be fertile and able to conceive children in order to enjoy marriage.[21] However, the Court went on to hold:

> "it is for the Contracting State to determine inter alia the conditions under which a person claiming legal recognition as a transsexual establishes that gender re-assignment has been properly effected or under which past marriages cease to be valid and the formalities applicable to future marriages (including, for example, the information to be furnished to intended spouses)"[22]

thus allowing Member States to decide the terms upon which a trans person can marry in their new gender. States who wish to claim the right to be exempt from affording privacy and marriage rights to transsexual people will have to show that there is, or will be, a substantial detriment to the public interest.

States must also ensure that transsexual people who wish to marry in their new gender role can do so. This implies creating a mechanism whereby a transsexual person can claim legal recognition of their preferred gender role. However, States have the right to determine the conditions under which transsexual people have the right to marry. These might be, for example, post-operative[23] status, or a requirement that future spouses are told of the trans status. Put simply, the conditions required to obtain a valid marriage to a member of the opposite gender may well be stricter than the requirements to have birth certificates changed.

In the case of *Grant v United Kingdom*[24] (2006) the Court held that the State had contravened the right to private and family life (Article 8 ECHR) of a trans woman by refusing to pay her a pension as a woman at the age of female retirement, indirectly supporting the slightly earlier decision of the ECJ in *Richards* (see below).

Also, in the Irish case of Lydia Foy an application to the ECHR was withdrawn after the State agreed to recognise her new name, however, the Court went further by making the first declaration of incompatibility of an Irish law with the European Convention on Human Rights.[25] The Irish Government has created a working group to look into complying with European law in this area.

Finally, there has recently been a successful decision by the ECHR in favour of a Lithuanian applicant. *In L v Lithuania*[26] the Court held that L's right to private and family life had been contravened when he was unable to obtain, in Lithuania, the gender reassignment treatments he needed in order to receive legal recognition in his new gender. Lithuania did not ban gender reassignment surgeries, and the Civil Code included a superior code to allow gender reassignment surgeries, but the sub-code which would facilitate the process of developing these medical services had never been implemented. The State had argued that L could access surgery abroad, and the State might even fund it, but the Court held that this hypothetical system which nobody had ever made use of, was not enough to avoid State liability.

[20] I, Supra at note 5, para 81.

[21] Goodwin, Supra at note 5, para 98.

[22] I, Supra at note 5, para 83.

[23] See note 13 above.

[24] Supra at note 5.

[25] Irish Law Updates, November 19 2007, acc: 14 /12/07 at **http://www.ucc.ie/law/irishlaw/blogger/2007/11/transgender-law-lydia-foy-in-high-court.html**.

[26] Supra at note 5.

The European Court of Justice

Following the case of *P v S and Cornwall County Council* relating to employment, there have been two key pension cases at the European Court of Justice: *K.B. and National Health Service Pensions Agency, Secretary of State for Health*[27] *and Richards v Secretary of State for Work and Pensions*[28]. In both cases, the decision of the ECJ in *P v S* was upheld. In *K.B.* (2004) the Court held that – following the ECHR decision in *Goodwin* – a person could leave their survivor pension benefit to their unmarried partner even when it was only available to married spouses. In this decision, the ECJ considered the fact that they were unable to marry because one of them was transsexual (and this was in breach of the ECHR case law). In *Richards* (2006), it was further held that where trans people were living permanently in their new gender role at the age of retirement for people of that gender, then they are entitled to collect a work related benefit (pension) which was available to people of their gender, regardless of any medical treatment or legal recognition.

Conclusions

At the European Union and the Council of Europe levels, the judiciary have taken the pleas of trans people very seriously since 1996. Wherever possible – with regard to the wide margin of appreciation of States – they have contributed considerably to extending European legal protection in the area of gender and transgender rights.

However, all is not resolved, because regardless of the directives, case decisions and national legislation, transgender and transsexual protection and legal accommodation in Member States of the European Union is still very disparate. Public authorities are unaware of, or lack the willingness to, implement their obligations. In many States trans people have no idea of the rights that have been recognised by case law and legislation. Furthermore, many trans people are so burdened by the fear and shame they carry, and the discrimination and inequality they face, that they have no emotional strength or will left to try and ensure their rights.

The main issues

The major concerns that trans people face in Europe are continuous discrimination and inequality in all aspects of their lives: their jobs, their homes and on the street. As can be seen in the rest of this report, the figures of trans people who have suffered from discrimination and denial of rights are astonishingly high. This must in part be due to limited action on the part of the EU Commission in ensuring States properly implement EU directives to protect trans people against discrimination. The EU Commission needs to set up a mechanism to ensure respect for court decisions against governments regardless of whether the State was a party in the case.[29] Applicants need to be able to take legal action, quickly and at minimum cost, when individuals or companies have contravened European legislation whether despite, or because of, a failure by government to implement an EC/EU Directive.[30]

Secondly there must be a social change in the image of trans people. Trans people in Europe are all made to look ridiculous; from the outrageous talk shows in Italy and Portugal, to the poor black Africans

[27] Supra at note 4.

[28] Supra at note 4.

[29] By which they may sometimes get round the problem of non-horizontal enforceability of EC/EU Directives.

[30] Following the direct effect of directives stated in *Francovich v Republic of Italy* ECJ (1995) ICR 722, ECJ Cases C-6 and 9/90 (also reported at [1992] IRLR 84 and [1993] 2 CMLR 66).

working as prostitutes on the streets of Paris, and the alternative – a slightly mad pathetic individual who must not succeed because they are different from other people. It is only now, in 2008, that trans people can say they have managed to open a few doors and started to negotiate for change in Europe.

Finally, for change to be real, a sort of social experiment must take place, as it did in the mid 1970s when the EU passed the Directive on Gender. In the late 1970s the EU made sure that throughout Europe women knew and claimed their rights; similar action is needed for trans people to be aware of their rights and remedies to discrimination. Trans people's social networks are efficient and reach far into the corners of Europe. Trans people firstly deserve their rights because they are human persons, and secondly because they do no harm to anyone by their desire to be a member of their preferred sex. The costs to society are minimal; the claim that trans health care is costly, and at the expense of other 'real' cases of need, is bogus if one takes on board the full costs. The UK trans campaigning group, Press for Change, has done extensive research on the cost to the State of gender reassignment treatments. In order for a trans woman to undergo these treatments including vaginoplasty would be around €10,000, and the cost of treatment including mastectomy and hysterectomy for a trans man would be around £8,000[31]. Compared with the costs of lifelong psychiatric care which, assuming monthly sessions and a short in-patient stay every two years, would cost around £4000 per annum, gender reassignment surgeries are a bargain. It should also be noted that psychiatric care would need to be continued for a very long time, as there has never been a published report, in the psychiatric or psychotherapeutic literature, of transsexualism or transgenderism being cured.

Recommendations

- The European Commission as guardian of the treaties should ensure that EU directives on equal treatment of women and men and gender equality are implemented to include protection of trans people against discrimination.
- Legal actions based on EU directives need to be revisited to ensure they are accessible by ordinary people in a manner which is quick and at minimum cost particularly when Member States have not implemented EU directives.[32]
- Funding is needed to ensure that trans people throughout Europe are made aware of their rights contained in the EU directives and the European Convention on Human Rights.
- States need to provide gender reassignment treatment without excessive restrictions.

[31] See Press For Change: Healthcare at **http://www.pfc.org.uk/node/613**.

[32] *Francovich v Republic of Italy* ECJ (1995) ICR 722, ECJ Cases C-6 and 9/90 (also reported at [1992] IRLR 84 and [1993] 2 CMLR 66).

Public Funding for:[1]	Psycho-therapy available	Hormone therapy available	Vagino-plasty available	Hair removal	Breast Augmen-tation available	Maste-ctomy available	Hysterec-tomy available	Phallo-plasty available	Metoidio-plasty available	Possible to Change Name Only?	What is Required To Change[5] Documents other than the Birth Record?
Austria	Occasionally	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No, Only After Mental Health Evaluation, Real Life Experience, Appearance, Hormone Therapy Required [12]	Mental health Evaluation, Real Life Experience, Appearance, Hormone therapy [12]
Belgium	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Nothing Required to change name
Britain	No	Yes	Yes	No	Occasionally	Yes	Yes	Yes	Yes	Yes	Nothing Required to change name
Bulgaria	Yes	Yes	Unknown	Unknown	Unknown	Yes	Yes	Unknown	Unknown	Unknown	Unknown
Cyprus[2]	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Czech Republic	Yes	Yes	Unknown	No	No	Yes	Yes	Yes	Yes	No, Mental Health Evaluation, Permanent Sterility Required	Mental Health Evaluation, Permanent Sterility Required
Denmark	Occasionally	Yes	Yes	No	Occasionally	Yes	Yes	Yes	Yes	No Mental Health Evaluation	Mental Health Evaluation, Hormone Therapy, Surgery to alter Secondary Sex Characteristics
Estonia	Yes	Yes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Yes	Unknown
Finland	Occasionally	Yes	Yes	Occasionally	Yes	Yes	Yes	Yes	Yes	No Mental Health Evaluation	Mental Health Evaluation, Real Life Experience, Permanent Sterility Required
France	Occasionally	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No Mental Health Evaluation, Appearance	Mental Health Evaluation, Real Life Experience, Appearance, Hormone Therapy, Surgery to alter Secondary Sex Characteristics
Germany	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No require Mental Health Evaluation and can be revoked if person gives birth or gets married	Mental Health Evaluation, Hormone Therapy, Surgery to alter Secondary Sex Characteristics, Permanent Sterility Required
Greece	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	No, Mental Health Evaluation Required	Mental Health Evaluation, Hormone Therapy, Surgery to alter Secondary Sex Characteristics
Hungary[3]	Yes	Unknown	Yes	No	Unknown	Yes	No	No	No	No Mental Health Evaluation	Mental Health Evaluation
Ireland	Occasionally	Yes	Occasionally	No	No	Occasionally	Occasionally	Occasionally	No	Yes	Nothing Required to change name
Italy	Occasionally	No	Yes	No	No but happens Occasionally	Yes but only Occasionally	Yes	Yes	Occasionally	No - After Mental Health Evaluation, Hormone Therapy, Surgery to alter Secondary Sex Characteristics, Permanent Sterility Required	Mental Health Evaluation, Hormone Therapy, Surgery to alter Secondary Sex Characteristics
Latvia	Yes	Yes	Yes	Unknown	Unknown	Yes	Unknown	Unknown	Unknown	No - Mental Health Evaluation, Hormone Therapy Required	Unknown
Lithuania	Yes	Yes, but for a limited period	Yes in principle, but there is No national provision	Unknown	Unknown	Yes	Yes	Yes, in principle but there is No national provision	Yes, but there is No national provision	Yes, but a gender neutral name only	Mental Health Evaluation, Hormone Therapy, Surgery to alter Genitalia, Permanent Sterility Required
Luxembourg	Yes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Yes, but gender neurtral name only	Unknown
Malta	Yes	Yes	No	No	No	No	No	No	Unknown	Yes	Yes
Netherlands	Occasionally	Yes	Unknown	No	Occasionally	Yes	Yes	Yes	Yes	No Mental Health Evaluation, Appearance	No Mental Health Evaluation, Appearance
Poland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unknown	Unknown	Unknown	Unknown
Portugal	Yes	Yes	Yes	Occasionally	Yes	Yes	Yes	Yes	Yes	No Mental Health Evaluation, Real Life Experience, Appearance, Hormone Therapy, Surgery to alter Secondary Sex Characteristics	No Mental Health Evaluation, Real Life Experience, Appearance, Hormone Therapy, Surgery to alter Secondary Sex Characteristics
Romania	Yes [4]	Yes [4]	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Spain	Yes	Yes	Occasionally	No	No	No	No	No	No	No Mental Health Evaluation, Real Life Experience, but - must be a sex neutral name	No Mental Health Evaluation, Real Life Experience, but - must be a sex neutral name
Slovakia	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Yes	Yes
Slovenia	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Yes	Yes
Sweden	Yes	Yes	Yes	Yes	Unknown	Yes	Yes	Yes	Yes	No Mental Health Evaluation, Real Life Experience, Hormone Therapy, Surgery to alter Secondary Sex Characteristics, Permanent Sterility Required[10]	No Mental Health Evaluation, Real Life Experience, Hormone Therapy, Surgery to alter Secondary Sex Characteristics, Permanent Sterility Required[10]

[1] See also EU legislation survey 'Access to treatment and healthcare'
[2] Law designed to decriminalise Homosexuality, also decriminalised Transgender/ Transsexuality
[3] But there is evidence that trans people have difficulty in securing funding – see P 7-8 Hungary Health and Social care document. This also states that mastectomy and penectomy are state funded but it is unclear what other procedures are. They call for a revision of state funding for GRS.
[4] The law is silent on transsexual and transgender people
[5] See EU survey legislation 'Documents'
[6] The EU Survey says Yes for many but TGUE survey shows that they may Not be changed, but amended, which shows a change has been made – thus little privacy.
[7] See EU survey marriage and family matters
[8] See LGBT Czech document – many institutions can not accept new docs as ID number is changed – Trans people regarded as 'new individuals' and many institutions do not have systems which can accept change of ID number – therefore trans folk have to keep disclosing and have no privacy
[9] See Birth Certificates document – Finland is the only EU country where Birth Certificate is changed before Surgery to alter Genital sex, but there must be permanent sterility by Hormone therapty or other means.
[10] Under review
[11] Under review
[12] The Council of Europe's Commissioner, Hammarberg, criticised the Austrian authorities for requiring genital surgery as the only option for legally changing one's gender. (TGEU 20/12/2007)
[13] In the case of Lydia Foy, in May 2007, Ireland's High Court held that the system of birth registration in Ireland is incompatible with the convention as it prevents Dr Foy's registration as

Is this by Court or Administrative Function?	What Documents can be changed by this method?	Possible to Change Birth Certificate? [6]	Is it possible to Stay Married after Change of Legal Gender? [7]	Can you Marry In new gender role?	Trans Discrimination Protection in law	Is it possible to gain Privacy Protection concerning previous gender role?	Parental [15] Rights- Will trans people still have access to their children after marriage breakdown?	Do trans people have Pension rights in new gender role?	Trans Hate Crime Legislative protection
Administrative at Registry Office	School reports Work reports	Yes. Or modified, but Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required	No	Yes	No	No	Occasionally	No	No
Court	Diplomas, Certificates	Yes, after Gender Recognition Certificate, which requries Mental Health Evaluation, Hormone Therapy, Permanent Sterility	No - must dissolve to get Gender Recognition Certificate	Yes	No, General male/ female protection	Yes	No	Yes	Yes
Administrative Function	Yes by concession, except Birth Certificate	Yes after Gender Recognition Certificate, which requires [5] Mental Health Evalaution and Real Life Experience	No, must dissolve to get Gender Recognition Certificate	Yes after Gender Recognition Certificate	Yes in Employment	Yes	Yes	Yes after Gender Recognition Certificate	No - in December 2007, Govt refused to include Trans in Criminal Justice Act amendements
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	No
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	No
Administrative Function	None	Yes, But [8] and Mental Health Evaluation, Hormone Therapy, Secondary Sex Characteristics Surgery requried	No	Unknown	Not explicitly	No – Lose access to children	No – Lose access to children	Unknown	Yes - in general terms, Hate Crime Records do not record Gender Identity
'juridical' Administrative Function	School certs	Yes but Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required	Yes re/ Old marraige/ No to new marriage	Yes	Yes	Yes	Yes	Yes	Yes in general terms
Court	Unknown	Unknown - but the presumption is Yes as it is possible to marry legally in the new gender role	No	Yes	No	Unknown	Unknown	Unknown	Unknown
Administrati-veistrative Function	None	Yes [9] but requries Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required	No	Yes	Yes [16]	Yes	Yes	Yes	Unknown
Court	Birth Certificate	No but amended, Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required	No	Yes	No	Unknown	Unknown	Unknown	No
Court	None	Yes but Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required	No	See TSG reform, still requires name change then change of legal gender, then Yes	Yes	Yes	Yes	Yes	Yes in general terms
Administrative Function	Seems all, including ID card, but not Birth certificate	No - but amended, and Mental Health Evaluation, Hormone Therapy, Secondary Sex Characteristics Surgery Required	Unknown	Yes	Unknown	Unknown	Unknown	Unknown	Unknown
Registry office Administrative Function	None	Yes - unclear requirements	No	Unknown	Yes, Code CXXV 2003	General: right to Equal treatment, protection from Discrimination, Harassment	No – lose rights as guardians of children	No	No
Court	No but [13]	No but [13]	Yes	No	No, except in general male/female protection	No	No	No	No
Court	Court records	No	No	Yes	No	Unknown	Unknown	Occasionally	No
Court	Unknown	Unknown	Unknown	Yes	Unknown	Unknown	Unknown	Unknown	Unknown
Court	Yes, but only after Genital surgery [10] which may be impossible to obtain	Yes, but Mental Health Evaluation, Hormone Therapy, Permanent Sterility Required, and only after Genital Surgery which may be impossible to obtain	Yes	Yes	No	No	Unknown	Unknown	No
Administrative	Unknown	Unknown	Unknown	Yes	Unknown	Unknown	Unknown	Unknown	Unknown
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Court	Unknown	Yes	Yes	Yes	General TG Not spec.	Unknown	Yes	Yes	Yes
Unknown	Unknown	Unknown	Unknown	Unknown	Yes - the 1997 Constitution bans discrimination on any grounds, but there is no evidence of it being used by trans people	Unknown	Unknown	Unknown	Yes in general terms
Court	None	No	No	No	No	Unknown	No	Unknown	No
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Court	All except Birth certificate	No, Must Dissolve to get Legal Recognition in new gender	No, Must Dissolve to get Legal Recognition in new gender	Yes	No	Yes	Rarely	Yes	Yes in general terms
Unknown	Unknown	Unknown	Unknown	Yes	Unknown	Unknown	Unknown	Unknown	Unknown
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Administrative Function – approval by national board of health	Unknown	No [11]	No [11]	Yes	No[17]	No[18]	Yes	Yes	No

female at birth.
[14] In September 2007, in response to the case of L v Lithuania app.27527/03 the ECtHR has recently held that Lithunia must adopt the required subsidiary legislation to Article 2.27 of its Civil Code on the gender-reassignment of transsexuals, enabling genital surgery within the state, within three months. It is Not yet known what action has been taken.
[15] See above 'likely to face difficulty with custody of children
[16] 2005 Act on Gender Equality. The act applies also for discrimination faced by trans-people. According to a statement given by government's committee for employment and equality the discrimination regulations are to be interpreted in a way that they also cover discrimination based on a sex-change (see ILGA Finland LGBT rights in Finland).
[17] Under review – currently general
[18] Change of details are classified – No-one can trace previous details

Results of the Legal Survey

In this survey of the States' provisions for trans people, we accessed previous surveys, documents printed or on the internet, and word of mouth if it was verifiable. It is impossible to say if this survey is completely accurate, there are a few States in the EU where it is still impossible to get any information. It might well be that there has been no legal response to trans people in those States, and if that is the case, this is highly detrimental to trans people and contributes to their exclusion and violation of their rights.

Public Funding for Gender Reassignment Treatments

Psychotherapy

Thirteen (13)[33] of the twenty seven (27) EU Member States provide funding for psychotherapy, which is not limited to a mental Health Evaluation of the patient. Most trans people benefit considerably from around ten psychotherapy sessions, and the World Professional Association for Transgender Health (WPATH formerly HBIGDA) highly recommends it as productive care for the well being of the patient. Some countries occasionally provide for it, notably Austria and Italy, both countries where as yet there is no form of legal recognition of the trans person's new gender; and Denmark, Finland and the Netherlands who do provide legal recognition of some form. The notable exception is the UK where psychotherapy is not funded, despite most other treatments being available on the National Health Service (NHS). The reason for this is the high cost of psychotherapy and the fiscal limits of the NHS.

Hormone replacement therapy

With the exception of Italy, nearly all of the seventeen (17) countries[34] for which we have information publicly fund Hormone Replacement Therapy.

Hair removal

Only two (2) countries, Germany and Sweden, provide public funding for hair removal. This is a real disappointment in that facial and perineal hair removal is essential in order to successfully live as a woman and to go on to successful genital reassignment by vaginoplasty. The cost of hair removal by electrolysis will be around €6-7,000, and by laser treatment (which does not scar the face) it would be around €9-12,000. This greatly exceeds the cost of breast augmentation and is similar to the cost of full genital surgery.

Surgery to alter secondary sex characteristics

Six (6) countries[35] fund breast augmentation surgery for trans women, in contrast trans men are much better supported with sixteen (16)[36] countries publicly funding bilateral mastectomies and fifteen (15)[37] funding hysterectomies.

Surgery to alter primary sex characteristics (the genitals)

Thirteen (13) States[38] fund vaginoplasty for trans women, and a similar figure provide phalloplasty for trans men. The exceptions to providing both treatments are Latvia where vaginoplasty is available and, surprisingly, the Czech Republic where vaginoplasty is not offered but phalloplasty, which is 4 to 5 times the cost, is reimbursed. However, when doing such a survey it is not possible to assess the quality of the treatments provided, and it may be that in the Czech Republic or other

[33] Belgium, Bulgaria, Czech Republic, Estonia, Germany, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Spain, Sweden.

[34] Austria, Belgium, Bulgaria, Czech Republic, Denmark, Finland, France, Germany, Ireland, Latvia, Malta, Netherlands, Poland, Portugal, Spain, Sweden, United Kingdom.

[35] Austria, Belgium, Finland, France, Germany and Portugal.

[36] Austria, Belgium, Bulgaria, Czech Republic, Denmark, Finland, France, Germany, Italy, Latvia, Lithuania, Netherlands, Poland, Portugal, Sweden and United Kingdom.

[37] Austria, Belgium, Bulgaria, Czech Republic, Denmark, Finland, France, Germany, Italy, Lithuania, Netherlands, Poland, Portugal and Sweden and United Kingdom.

[38] Austria, Belgium, Denmark, Finland, France, Germany, Italy, Latvia, Lithuania, Netherlands, Portugal and Sweden and United Kingdom.

countries phalloplasty surgery is very minimal and purely cosmetic, whereas in others such as Belgium and the Netherlands the surgery is extensive and produces a functional phallus through which ordinary standing urination is possible.

The Availability of Public Documentation Changes

Changing names and documents other than birth certificates

In seven (7) countries[39] it is possible for a trans person to change their legal name to a new legal name that is more appropriate to their new gender, without any legal obstruction. In another eight (8) countries a person can only change their name after they have undergone some medical intervention. In Finland, France, Hungary and the Netherlands this intervention consists of a simple mental health evaluation to discover whether the person has a gender identity disorder. In Italy, Portugal, Spain and Sweden this includes treatment up to and including surgery to alter secondary sex characteristics.

As for other documents, an even larger number of countries – thirteen (13) – require treatment up to and including surgery to alter secondary sex characteristics, of these Finland, Germany, Lithuania and Sweden require treatment up to and including treatment to render permanent sterility. Stephen Whittle wrote that:

> "any requirement of compulsory sterility for legal recognition of the new gender status could not be imposed equitably. To do so would coerce transsexual people with poor health to undertake inappropriate and even dangerous surgical procedures. Further it would be contrary to the principles of human rights... excluding from parenthood a set of people because they have certain characteristics which have no relevance to their ability to be a good parent must be outlawed because it runs counter to the dignity of human beings, who are unique, free and responsible for their actions".[40]

Policing trans people to prevent their access to parenting would be extremely difficult in practice, transsexual people have always found ways of living in their new gender role including the raising of children. We can already see this in the number of trans people from all walks of life who already care for children.

The legal requirement of sterility is an abuse that must be denounced in the strongest terms. It is particularly disturbing as it echoes back to the eugenics theories and practices of the late 1930s to the 1970s worldwide, but most notably in Europe.

Changing birth certificates

Among the fifteen (15) countries for which we have information, it is possible in thirteen (13) States to have a birth certificate issue recording new details relating to the new gender. Most States have complex requirements before a new birth certificate is granted, which include gender reassignment surgeries. The UK and Spain are exceptions in that requirements are very liberal. Genital surgery is not a pre-requisite for a new birth certificate. They require nothing more than a mental health evaluation showing the person has gender dysphoria and a period of two (2) years living permanently in the new gender role.

[39] Belgium, Estonia, Ireland, Malta, Slovakia and Slovenia and United Kingdom.

[40] Press for Change report in: Home Office (2000) The Interdepartmental Working Group Report on Transsexual People, London: Home Office, HMSO.

In France, Germany, Greece, and sometimes in Austria, a new certificate will not be provided but the old one will be amended by dated annotations on the original. This has the effect of failing to protect a person's privacy.

Again, we have the same concerns about the requirements for permanent sterility before accessing a new or amended birth certificate. Following on from this, there are still several countries that do not allow trans people, even those who have a new birth certificate, to marry a member of their birth sex, although sixteen (16) countries do permit this.

Extent of Recognition and Protection

Denmark, Finland, Germany and Hungary provide broad transsexual and transgender protection against discrimination, the law in the Netherlands is expressed in terms of 'transgender' but in practice it is held to include transsexual people. Both the Czech Republic and Poland have constitutional or codified general anti-discrimination laws, which do not use the words transsexual or transgender, but which are regarded as providing protection, although in reality trans people and their legal advisors are probably unaware of this potential protection. Nine (9) countries provide no protection, despite the decision in *P v S and Cornwall County Council*[41] in 1996, which really does show the need for the EU Commission to put pressure on Member States.

On 21 December 2007, Member States were required to implement the *Directive on the Principle of Equal Treatment between Men and Women in the Access to and Supply of Goods and Services* (2004/113/EC), into national law. This protection includes trans people who are "intending to undergo, undergoing or who have undergone gender reassignment". Very few, if any, have done so at the time of writing; it seems that States choose the European law they want, but simply ignore the laws they do not want.

Only four (4) countries, Belgium, the UK, Spain and Sweden provide specific privacy protection for trans people in their new gender role. In the UK it only comes into place after the person has obtained a new birth certificate or equivalent.

There are only six (6) countries where trans people are likely to retain access to their children after they have been divorced, which is clearly very problematic. As Richard Green's research has repeatedly shown over the last 40 years, on a long term follow up on the children of trans parents:

> "Available evidence does not support concerns that a parent's transsexualism directly adversely impacts on the children. By contrast, there is extensive clinical experience showing the detriment to children in consequence of terminated contact with a parent after divorce."[42]

Finally, only three (3) countries provide specific pension provision after a legal change of gender despite the ECJ decision in *Richards*[43] and the ECHR decision in *Grant*[44], and only two (2) - Belgium and Denmark - provide specific protection against transphobic hate crime. In the UK, transgender hate crime is now counted in official police hate crime statistics, but at the last minute late in 2007, the Government withdrew amendments to create 'incitement to transphobic hatred' protection from the Criminal Justice (Amendment) Bill.

[41] Supra at note 4.

[42] Green R., (1998) Transsexuals´ Children. IJT 2,4, **http://www.symposion.com/ijt/ijtc0601.htm**.

[43] Supra at note 4.

[44] Supra at Note 5.

Health Policy in the EU: the Impact on Healthcare Equalities Strategies for Trans People

EU and National Health Care Policies

Health policy within the twenty-seven Member States of the European Union, as with countries throughout the world, is continuously developing as policymakers aim to strike a balance between many variables that contribute to the efficacy of healthcare systems. Reforms and systemic restructuring are frequent and substantial. As medicine evolves, States look for the most effective ways to take advantage of available resources. Whilst developing healthcare systems, policymakers must maximise the availability of skilled practitioners, contain costs of new technologies and treatments, recognise shifting population demographics, and account for increases in demands for services and changes in patient expectations. These are just some of the factors that must be carefully considered whilst developing policies that will most successfully meet the needs of the population.

Europe has a long tradition of playing host to innovation and leadership in healthcare, including a strong history of quality medical training and public health provision. In the present day, the European Union has taken a leading role in identifying health priorities for its Member States and has a major influence on European health policy (Randall, 2001). Yet it is each individual country, rather than the EU, that maintains direct responsibility over the policy and the provision of healthcare for its people, resulting in a multitude of service delivery systems among Member States. From one EU country to the next, there are significant differences in the ways in which healthcare is financed and is carried out. However, regardless of these differences, national policymakers in Europe have reached consensus on the primary objectives of healthcare services. According to McKee, MacLehose and Nolte (2004), their priorities are universal access for all citizens to high-quality effective care which is responsive to patient concerns and efficient use of resources.

Although each country's healthcare system is unique, policymaking and coordination at the European level are important for a number of reasons. The Single European Act gave the European Commission a regulatory role in the market of healthcare goods and services. The Maastricht and Amsterdam Treaties further defined the EU's role in health by encouraging and lending support to cooperation between States and international organisations, by integrating health into EU policies, and by promoting consumer health, safety and economic interests (Randall, 2001). Aside from the importance of the EU's role in the healthcare market, it is recognised that there are areas in health and medicine where cooperation among countries is valuable in ensuring a high level of human protection. This is of particular significance for issues that involve cross-border impact, the movement of people and the public health of the European Community (Commission of the European Communities, 2007).

Concurrent with these duties, the European Union is looking for ways to coordinate social protection and inclusion policies. This includes efforts to tackle disparities in health due to social, economic and environmental inequalities (Randall, 2001). Transgender and transsexual healthcare service users are among the groups that may greatly benefit from this coordination. As trans people are often vulnerable to social and economic discrimination, it is essential that policymakers recognise the effect that this can have when discrimination and prejudice against trans people is institutionalised, from frontline service delivery to discrimination in healthcare funding decisions made locally and nationally. It is vital that healthcare policies are critically evaluated to ensure that trans people's unique circumstances and needs are taken into consideration. Inequalities must be

recognised and addressed so that trans people can access appropriate healthcare and, more broadly, can move towards social parity.

Acknowledgement of the divisions in responsibility that exist in healthcare policy formation is helpful in developing the best ways to frame transgender and transsexual health care. In the context of multiple healthcare systems, it is vital that any move towards equalities priority setting by the European Union takes into consideration the complexity of funding mechanisms that hold power over individual care. Setting overall strategies needs to make clear allowances for each type of system, whether private or public insurance schemes, publicly-funded models or mixtures of each. To make equality work, equality mainstreaming needs to penetrate each level of healthcare provision, from national healthcare priority setting to municipal budgeting arrangements, and it must also remain relevant to each healthcare paradigm.

The ten examples in the following section illustrate the complexities that exist in healthcare arrangements within the European Union. The aim is to acknowledge the amount of variation in healthcare provision between Member States and to offer a degree of insight into several challenges that countries are currently facing, illustrating the differences in healthcare system configurations and demonstrating the array of historical and social traditions that exist across Europe. In an attempt to maximise diversity in the following examples, geographic location, type of system and date of accession into the European Union were considered. Among those chosen, four countries have been Member States for over a decade (Finland, France, Germany and the UK), four countries joined the EU in 2004 (Cyprus, Hungary, Lithuania and Poland) and finally, two States joined the EU in 2007 (Bulgaria and Romania). More extensive research on the healthcare systems of each European country may prove helpful in considering specific provisions for trans people going forward, but is beyond the size and scope of this project.

An Overview of the Healthcare Arrangements in Ten Countries of the European Union [45]

Bulgaria: In the new EU Member State of Bulgaria, health insurance is mandatory. A basic health package is provided by a single National Health Insurance Fund with health insurance funds split up into 28 regions. For services outside of this package there are also 11 voluntary insurance funds and the option of out-of-pocket services. In Bulgaria, patients have choices in some areas of their care, such as the selection of general practitioners and inpatient facilities. Services are publicly funded but often privately provided by practices that have contracts with the Health Insurance Fund. Due to economic decline in the 1990s, healthcare spending has decreased in relation to Gross Domestic Product (GDP) and a growing share of the financing is coming from out-of-pocket payments (Arnaudova, 2006). However, Bulgaria has plans to increase spending on health over the next few years using funds generated by privatisation and increased insurance contributions, as well as EU structural funds (Ministry of Health of the Republic of Bulgaria, 2007).

[45] It should be noted that reforms in the health care sector are frequent and the information contained within this document is accurate as of the individual dates of attribution.

Cyprus: Health services in Cyprus are provided to a high standard by a mix of public and private funding such as public health schemes, employer and trade union funds, and private fee-for-service provision (Golna *et al*, 2004). Each system operates independently of the other, at times creating duplication of services. Around 65% of the population receive State health services at no cost, with eligibility being determined by profession or income, and a further 15 to 20% receive services at a reduced cost (Antoniadou, 2005). Cyprus is the only EU State that does not provide a universal healthcare system. It is moving towards the creation of a National Health Insurance Scheme but, due to continuing debates over its implementation, this scheme has not yet been realised (Antoniadou, 2005; Chritodoulou, 2005).

Finland: Finland is a country where healthcare has held a high priority as a public responsibility (Järvelin, 2002). The Finnish Constitution specifies that public authorities must provide everyone with access to healthcare services, regardless of place of residence and/or the ability to pay. Organisation of healthcare in Finland is decentralised through division among municipalities and is mainly funded by taxation. These relatively small municipalities prioritise spending according to local need. A very small number of Finnish people maintain private health insurance. The comprehensive healthcare system of Finland has long held widespread support among the population; more than 80% of the population express satisfaction compared with an EU average of 43% (European Commission Survey as cited by Järvelin, J. 2002).

France: Since the Universal Health Coverage Act of 1999, health insurance in France has been compulsory and universal (Sandier *et al*, 2004). There are a number of different health insurance schemes: a general scheme that provides coverage for around 75% of residents, an agricultural scheme for agricultural workers, and a social scheme for independent professionals. Additionally, there are several other schemes that are set up for employees of specific industries. These health insurance plans are branches of the social security system. Funds are generated from various forms of taxation, with contributions based primarily on income. Of individual healthcare costs, around three quarters are reimbursed, whilst the remaining quarter is funded by co-payments (Saliba and Ventelou, 2007; Couffinhal and Perronnin, 2004 as cited by Saliba and Ventelou, 2007). Many people have supplemental insurance policies that cover statutory schemes where both the individual and the state share the cost of some health care.

These policies are either provided through employers or purchased individually. In France, patients are given a great deal of choice of healthcare providers, can directly access specialist services, and benefit from an exceptionally high quality of care. There are, however, persistent concerns about how funding will be maintained as real costs continually exceed budgeting targets.

Germany: Germany has a tradition of health insurance based systems dating back to 1883. Currently, the healthcare system is funded by compulsory contributions that are split between employers and employees and are put into one of a large number of sickness funds. These 252 sickness funds, which insure around 90% of the population, determine the level of financial contribution and the type of healthcare services that are received (Busse and Riesberg, 2004). Chancellor Angela Merkel has made reform of the German healthcare system a high policy priority and many changes are expected. For example, whilst the current system is decentralised and a great deal of power rests locally, planned reforms will develop a new centralised budget. Levels of contribution

will be standardised and the funds will be redistributed according to government calculations. Though this approach is meant to improve the financial outlook of the German healthcare system, long term affordability remains a strong concern and many medical practitioners and health federations are pessimistic about the effect of these reforms (Bousfield, 2007).

Hungary: There have been many transformations in Hungarian healthcare following political changes in the late 1980s, due in part to the widening gap of health indicators between itself and western European countries at that point in time. It has evolved from a centralised and nationalised system under communism towards a more decentralised and privatised system during the development of Hungary's multi-party democracy (Gaál, 2004). The National Health Insurance Fund Administration (NHIFA) administers the vast majority of social health insurance funding in Hungary. Healthcare is organised on the basis of municipality, and service delivery is provided mainly by local government-owned public providers through contractual agreements with the Administration. Close to 80% of GPs are privately contracted by local governments, around 20% are on fixed salaries that are paid by the local government and, finally, a small percentage of GPs have independent practices (Arnaudova, 2004). The health services are regulated by the national government using a system of statutory supervision.

Lithuania: Over the last twenty years the health sector of Lithuania has undergone many structural changes as its political system moved from communism to parliamentary democracy. These changes have shifted the healthcare system from an integrated and centralised system to a decentralised, contract-based organisational structure (Cerniauskas and Murauskiene, 2000). Health insurance is provided by the National Health Insurance Company (State Patient Fund) and its five territorial branches. As of 2004, 74% of health sector financing was from statutory insurance and taxes, and 23% was from private insurance accounts (Arnaudova, 2004). Among the many reforms that have been introduced, the most significant have included"…strengthening primary healthcare, reducing hospital capacity, implementing a social health insurance system and improving the quality of healthcare services" (Bankauskaite and Jakusovaite, 2003). Despite these efforts, Lithuanian healthcare must still cope with a number of persistent ethical problems as well as low levels of patient satisfaction (Arnaudova, 2004).

Poland: Poland's healthcare system, a mix of public and private financing arrangements, continues to undergo reforms that are intended to improve coherence and consistency in medical care (Arnaudova, 2004). In 2003, Poland's regional sickness funds were merged into a newly introduced compulsory health insurance scheme called the Narodowy Fundusz Zdrowia (NFZ) or National Health Fund. This central fund and its regional branches are now responsible for administering the country's social healthcare scheme by planning and purchasing health services (Kuszewski and Gericke, 2005). In addition to the NFZ, there are options of a voluntary health insurance scheme for self-employed people or those not insured by their employers and packages of healthcare offered by private clinics or insurance companies. A recurring theme in the literature is key concerns about the funding of healthcare in Poland. Spending is low relative to the country's growing GDP and there is a discernible unhappiness among healthcare practitioners due to low salaries in proposed new contract agreements (Kuszewski and Gericke, 2005).

Romania: International influences are currently driving healthcare reforms in two major areas, primary care and health insurance (Vladescu *et al*, 2000). Frequent changes in Romanian political and managerial leadership have resulted in a low degree of success in healthcare reforms (Arnaudova, 2006). At present, the National Health Insurance Fund (NHIF) exists as a mix of social insurance and public management models in a system that is almost exclusively owned by the State. Health insurance is mandatory and is funded through contributions linked to payroll taxes or, in cases where no employment based contributions are available, funds are provided to the NHIF from the State budget. Services are contracted from healthcare providers from funds at the district level. The World Health Organization recommends that further reforms in mental health are needed (Arnaudova, 2006).

United Kingdom: Since 1999, public healthcare organisation in the United Kingdom has been devolved into the autonomous National Health Services (NHS) of England, Scotland, Wales, and Northern Ireland. Each service has an independent economic and managerial structure, but remains reliant on the Parliament in Westminster for funding. Founded in 1948, the NHS was to be universal, comprehensive, and available to all equally on the basis of need. Over the past fifty-nine years, the NHS has grown to become the largest organisation in Europe (Department of Health, 2007). Healthcare under the NHS is funded by general taxation and provided free at the point of delivery for residents. In England, by far the largest system of the four, management responsibility for healthcare lies with the Department of Health and decisions about service delivery and local priority setting fall to Strategic Health Authorities and, more locally, to Primary Care Trusts. Whilst in previous years the NHS was a relatively self-sufficient and insular public system, more recent reforms have introduced market mechanisms and increased managerialism to the health service (Talbot-Smith and Pollock, 2006). These trends are set to continue as the government looks for ways to improve the responsiveness and cost-effectiveness of the system, whilst maintaining its new commitment to a 'patient-centred' NHS.

Discussion

The variation in healthcare systems as outlined above, results in dissimilar positions for trans patients within the national health schemes of the European Union. Systemic variations, along with differences in treatment philosophies, can influence the options that are or are not available under public healthcare systems. Due to the several different types of funding arrangements at a national level as well as differences in local priorities, drawing together European-wide policy on transgender and transsexual health presents us with some great challenges. As very little has been published on this topic it is difficult to get a sense of the overall picture of healthcare for trans people in Europe. However, this lack of publication and research does not reflect the active social advocacy networks for trans people at the local, national and European levels. The low priority placed on trans-related research and policy development is further evidence of social and political exclusion experienced by trans people. Though it may seem difficult to organise the type of coordination that is required to fight discrimination in healthcare provision and other areas of policy development, it is imperative that inequalities are addressed and actively tackled.

Inclusion or Refusal

At present, some European countries provide comprehensive services for trans people who transition, including psychological, hormonal and surgical treatments as part of their public healthcare schemes, whilst other countries specifically discriminate against trans people by categorically refusing to provide transition-related medical services. In the United Kingdom, most health authorities within the National Health Service do provide services to transsexuals, though waiting lists can be long and care is rarely provided locally (Murjan *et al*). 'Healthcare Wales' which provides NHS care and funding for residents of Wales currently refuses to fund any assessment or treatment services to trans people.

Some countries have explicit exemption policies to funding services related to gender reassignment. In Poland, for example, a decree by the Minister of Health in 2003 defined sex reassignment surgery as a "non-standard health service" that is specifically excluded from being covered under the National Health Fund. This list also included "plastic surgery and cosmetic procedures if these are not connected with disease or its consequences, congenital malformation or injury" and "acupuncture, except for pain relief" (Kuszewski and Gericke, 2005). Other countries provide a mixture of public and private treatment options, but the availability of services often varies by locality.

One startling reality for those seeking transition-related services is that information is often very difficult to find. Policy in this area of medicine, including information about entitlement to treatment under national healthcare schemes, is not always made explicit. This can leave patients vulnerable to discrimination and prejudice if they come across a practitioner who is unwilling or unable to treat them. Some patients find themselves in the precarious situation of having to advocate for themselves with few resources and very little, if any, systemic support. For the practitioner, the relatively small population of trans people means they may not have developed the knowledge required to meet the healthcare needs of the patient, whether related to general healthcare or specifically to transition-

related care. It is therefore the case that flexible, patient-centred approaches are needed and necessary to successfully treat the members of this diverse group. Without better coordination and support within each healthcare system, even practitioners with the best intentions may not know what specific treatments are available for trans people or how to plan the best way forward.

The challenge of creating European-wide transgender and transsexual healthcare policy that will work towards fairness can be met in a variety of ways. Though the limited role of the EU in creating healthcare policies within the Member States may hinder its ability to completely coordinate services provided within national borders, it can make use of the power of directives and take a leading role in promoting equality and justice for this marginalised group. As an example of how this has been done previously with regard to transsexuals, we can look at the work of the Council of Europe's Parliamentary Assembly, who used their power to recommend changes in legislation to Member States. The recommendations that they made, at least affirmed the importance of recognising transsexuals' legal status in accordance with the case law of the European Commission of Human Rights and the European Court of Human Rights (Parliamentary Assembly, 1989). Unfortunately, the call from the Parliament was too advanced for Member States who could not conceive of trans people, (normatively understood as mentally ill), as a group needing protection from discrimination and there was virtually no response to it.

Data Analysis

Methodology

The data gathering and analysis for this research was a collaborative effort, involving researchers, translators and a systems engineer who built the code for the survey results database. The data for the following discussion is derived from an English online survey which was then translated into Danish, Swedish, Maltese, Polish, Russian, German, Greek, French, Dutch, Spanish, Finnish, Italian and Hungarian and Focus Groups which were hosted in Austria, Finland, France, Holland, Hungary, Italy and Spain.

The Survey

The questions for the online survey were based upon an online survey conducted by Whittle and Turner (2007) in the UK which was commissioned for the Equalities Review (2007). There were several changes which had to be made regarding the different classification systems for countries – for example, occupational class and educational levels. These were changed to follow those used in the European Social Survey[46] which included categories which were more European-specific.[47] The survey was written in English and then sent to the translators in different countries. The total number of questions was 97, asking about the general profile of respondents – age; living arrangements; occupation; savings; marital status; when they transitioned; disability; employment; earnings; whether they were living full-time in their acquired gender and what documentation had been changed. Other questions covered all aspects of life including experiences at work; school; college and university; neighbourhoods and public spaces; using toilets and leisure facilities and the criminal justice system. For the purposes of this report, there were twelve questions specifically on healthcare (see Appendix) which asked questions about accessing clinical treatment as well as experiences of treatment by healthcare professionals.

The Translators

The translators were recruited by announcements on pan-national trans email lists. Translators were required to have an extensive and practical experience of the transgender and transsexual community and a high level of fluency in written and spoken English as well as some experience in arranging and running focus groups, and/or translation services.

Several issues regarding translation were encountered as much of the language used in the English version could not be directly translated. Some content had to be negotiated between the translator and the research team – for example the English term 'acquired gender' did not have an equivalent in many countries, as well as some of the identity categories in the survey: 'woman with a transsexual background; trans man'. These issues were solved by translators who, after checking what we were looking for, interpreted the question and translated it into an equivalent relevant to their country.

[46] The European Social Survey is a biennial multi-country survey covering 30 countries and is funded by the European Commission – see **http://ess.nsd.uib.no/**.

[47] For example with current migration patterns the European Social Survey includes a question on immigrant status. The survey also includes an occupational class of agricultural worker.

The Focus Groups

Additional data was gathered using focus groups as, given the short time frame for this research report, it allowed a large amount of data to be collected over a short period of time. This qualitative detail about participants' experiences while accessing healthcare adds a more personal dimension to the quantitative data. Translators from seven countries visited the UK for a training session on conducting the focus groups. This included how to recruit for the focus groups and the sensitivities of researching people who are part of a vulnerable group. The translators were given a short list of open–ended questions to use as a guide when conducting the focus groups and were asked to write a short piece about the composition of the focus group in terms of age and gender, how they identified and how much trans-related healthcare they had accessed.

Interpretation and Analysis

The survey was launched online in early October 2007, the focus groups were conducted in October and the healthcare analysis began in late November. The systems engineer built a programme which would collate the results across the countries as well as on individual countries. Participants who had not accessed medical treatment for gender reassignment were screened out – as otherwise their 'negative' answers to questions regarding treatment would affect the statistics.

The 'Benchmark' System

We built a code for analysing the statistics using an 'Acceptable Baseline' measurement for some answers. Many questions were multiple choice; some answers were coded as Acceptable Baseline (AB) responses. For example, with the question below we chose the second answer as AB; this 'benchmark' was the minimum or best that trans people should expect when accessing healthcare:

When you first talked to a doctor or psychiatrist about your transition, how did they respond?	
Was informative and helpful	**Best practice**
Wanted to help but lacked information	**Acceptable baseline**
Did not appear to want to help	**Not acceptable**
Refused to help	**Not acceptable**

Conducting Focus Groups

As this research report focussed on access to healthcare, focus group participants were required to have experienced accessing gender reassignment-related healthcare. There were some country – specific problems with recruiting for focus groups. Trans people have different levels of visibility and politicisation across European countries and some translators informed us that in their countries trans people were not 'out' and tended to disassociate with the trans community. One translator encountered a problem setting up a focus group as the country was geographically large with small scattered communities and it would mean that most participants would have to travel very long distances. It was suggested by the translator that a 'virtual' focus group could be held in an Internet Relay Chat (IRC) room in 'real time'. It was agreed that this was a solution and a temporary private channel was set up through an IRC channel used by trans people in that country. People who the translator had previously met were invited to join – thus ensuring the 'authenticity' of participants. After the discussion the translator accessed the content by reading the backlog of the channel.

Translating Focus Group Discussions

The participants in each focus group ranged from 4 – 9 and were mixed (ftm)Trans men/ (mtf) Trans women. A total number of 12 FTMs and 24 MTFs and one non-gendered person participated.[48] Due to the constraints of this project it was decided that the whole content of the focus groups need not be translated completely – as this would be too costly and time consuming for the translators, as well as for the UK researchers to read through the content and analyse. Translators were therefore asked to pick out themes that emerged during the focus group and translate two narratives which succinctly summed up the response for each question. Translators then, were involved in the interpretation of the data and made decisions about which themes in the discussions to include.

[48] The individuals in the focus groups, as well as those who responded to the online survey, may not have strictly identified as 'female to male' transgender or transsexual men/ 'male to female' transgender or transsexual women but for the purposes of this report, the terms 'FTM' and 'MTF' are used, as they are generally understood as a shorthand for people moving away from the gender they were assigned at birth.

A Profile – the Online Survey of Trans People?

As of 18 December 2007, 2575 respondents, almost all of whom claim a trans identity of one sort or another, had completed what they felt were the relevant parts of an online survey. The survey was provided in 13 different languages, attempting to cover all European countries including non-EU countries. By taking advice from community members through the Transgender European Network (TGEU)[49] on what language would be the primary language in a State and also the main second European language learnt at school, alongside evaluating States where there was use of a second language on a daily basis for many people, we considered these languages to cover most communities. We would also have chosen to have the survey in Russian to ensure inclusion of the Baltic States: Lithuania, Latvia and Estonia, but the Russian Cyrillic alphabet could not be used in the chosen survey template. At the time of writing this report, the survey is available to Russian language speakers at **www.transgender.ru**, an online support site for trans people who are Russian. At the time of writing this report the survey is still ongoing because other areas of the survey are to be analysed for a later report.

Who Responded?

Participants' chosen responses by language indicate significant differences in response rate:

Chart 1: Response Rate by Language as of 18 December 2007

Title	Responses
Trans Europe Survey 2007 (Dansk)	149
Trans Europe Survey 2007 (Svenska)	66
Trans Europe Survey 2007 (Malti)	2
Trans Europe Survey 2007 (Polska)	33
Trans Europe Survey 2007 (Deutsch)	565
Trans Europe Survey 2007 (Greek)	42
Trans Europe Survey 2007 (Français)	244
Trans Europe Survey 2007 (Nederlands)	187
Trans Europe Survey 2007 (Español)	36
Trans Europe Survey 2007 (Suomi)	100
Trans Europe Survey 2007 (Italiano)	64
Trans Europe Survey 2007 (Magyar)	75
Trans Europe Survey 2007 (English)	1012
	2575

[49] **www.tgeu.net**.

There are several possible explanations for this variation in response rate:

- the medical and legal frameworks under which some people live in their State may alienate them from other community members;
- the medical, social and legal frameworks may mean that few people feel they can identify as trans;
- a lack of social acceptance may mean trans people in some countries choose to disengage themselves from the social support or cultural spaces whereby they might hear of the project;
- historical differences in the legal mechanisms that exist within States may mean that some trans people are more politicised and willing to take part in such a survey than others;
- a failure in the promotion mechanism for the surveys.

One role of the translators was to use a snowball method for publicising the survey by using their links with the community, or the community's gender identity medical clinics, using email and asking for the message to be forwarded to as many relevant people as possible. Some had far better community links than others. In a couple of cases a translator had to be employed who had few, if any, links with the trans community, and this is noticeable in terms of respondents – for example in Malta, Poland, Greece and Spain.

From the lead researcher's extensive 30 year knowledge of the community, its legal background, and its historical and social placing,[50] it could be said that the monopolistic conservative medical systems of some countries – for example France, encourage trans people to 'disappear' into their new gender roles. In others, similar treatment monopolies exist which are closely linked with legal status recognition – for example The Netherlands and Belgium. In these States, only those trans people who accept the entire list of treatments offered are able to gain a new legal status. This tends to drive trans people underground, as they become institutionalised into accepting how shameful it is to still identify as trans post-transition.

One reason for the large English language response rate, compared to other languages, will have been the extensive politicisation of the UK trans community over the last 15 years through the work of a campaigning group: Press for Change.[51] Many UK respondents to a previous study in 2006 had also experienced positive feedback in terms of political acknowledgement of the problems trans people face.[52] This will have encouraged repeat participation as it would have been felt that the time invested was worthwhile. It is probably the case that the response rate has been high in the German language survey because the report from that study was given a high profile amongst the community, similarly in France.

The very small response rate from Spain and Italy is perhaps not so surprising when we recognise that gender reassignment was severely stigmatised until very recently, when the law was changed in 2006. Living as a trans person in Italy can prove very difficult because of the complicating factor of the Roman Catholic Church and its refusal to acknowledge any right of trans people to live in their preferred gender role. Legal recognition processes are weak, and ultimately many of the respondents would belong to 2 or 3 support groups in major urban centres such as Milan, Turin and Bologna. In both countries, as in Portugal, the only available employment option for many trans people has been involvement in sex work, and so the majority of trans people will have access to a social support network, but it will be highly localised and have little connection with statutory social support organisations.

In other European Union States there has not been a tradition of sex work for trans people. This

[50] Professor Whittle worked as a social advisor and support group leader in the UK from the period 1975-1990, then after graduating in law, he became a legal advisor and activist, a position he retains today. He has worked on social policy development in many European states, as a researcher with several EU projects, and as a legal and case advisor throughout Europe, with cases in both the European Court of Justice and the European Court of Human Rights.

[51] **www.pfc.org.uk**.

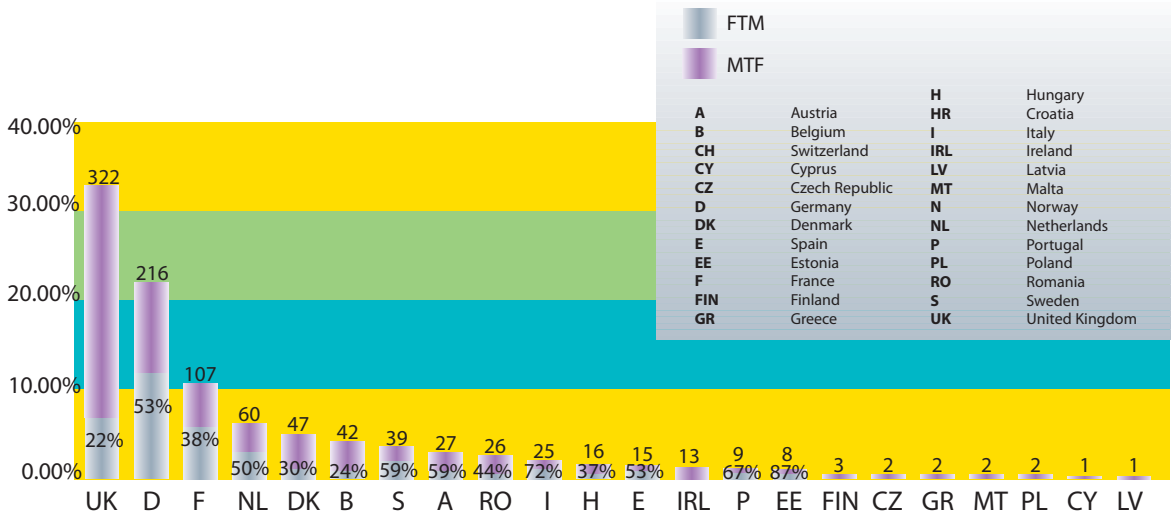
[52] Whittle, S., Turner, L. 2007 *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*, London: Cabinet Office. This report led to trans people being acknowledged by the then Commission for Equality and Human Rights as the 'seventh strand' of the existing 'strands' of inequality.

almost certainly arose out of conservative clinical settings which would have refused treatment for trans people who were getting paid for sex and is clearly evidenced by the failure of trans support groups to obtain funding for HIV work.

The analysis for this paper focuses on 615 (female to male) trans men, and 1349 (male to female) trans women, who were the survey respondents as of 1 December 2007 after incomplete or duplicate responses were removed. Only around 50% of these provided adequate information for the health care survey analysis.

Country Profile

Chart 2: Respondents by Country and Gender



The chart above shows the number of respondents by country and the breakdown by gender. The largest numbers of respondents were from the UK, followed by Germany and France. The FTM/MTF ratio is not at all consistent across countries, with Germany and The Netherlands being around 50%; Italy and Sweden having a larger ratio of FTMs to MTFs and the UK and France having a larger ratio of MTFs to FTMs.

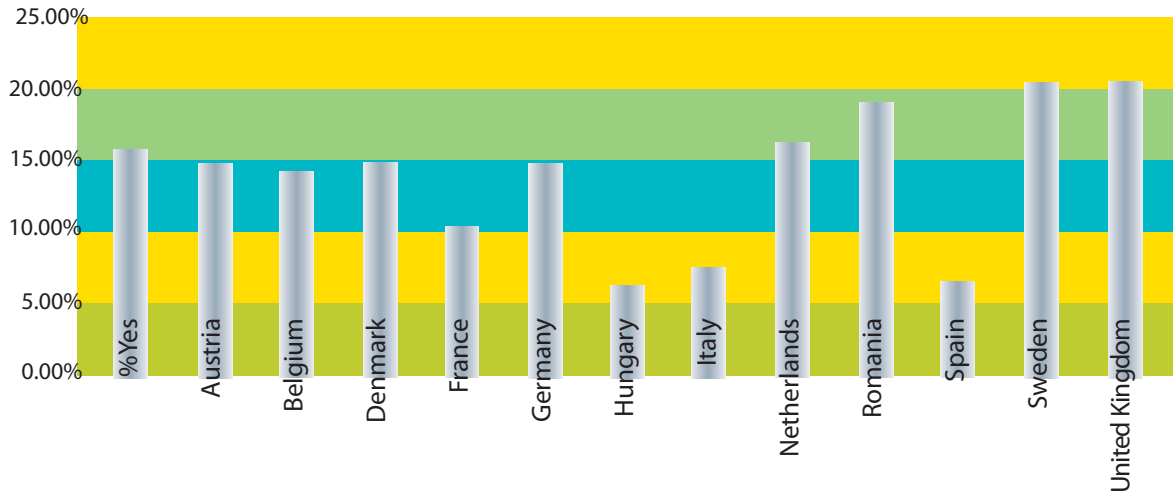
In order to see if our population of respondents was within the normative range of people who might respond to other surveys, we asked respondents several questions in which we would expect to see a normative relation to other citizens of EU 27, for example their age and salary, alongside several questions which might indicate variance due to their trans status.

Do the Respondents Represent a Normal Population?

Disability: We asked respondents if they identified themselves as having a disability. Of all valid responses 15.4% (n155) answered positively (see Charts 2 & 3). This is comparable to the figures obtained from other national and European studies.[53]

Across figures from twelve countries, as can be seen from Chart 3, most are within the range of 14 – 21%, with an average of 13.91%, and a median of 14.81%. This indicates that our respondents were a likely representative group of trans people, though there might either be some under-reporting or an on-average filter group, as with many trans people undertaking multiple surgeries one might expect a higher disability rate.

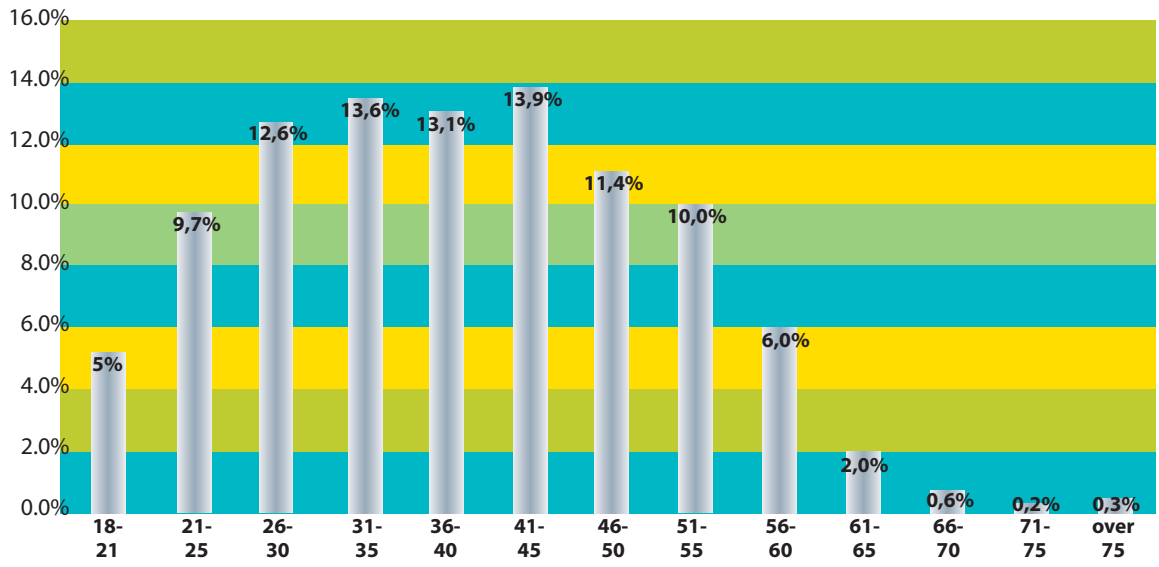
Chart 3: Total % of Respondents Who Identified as Having a Disability



Age: We asked the respondents their current age and also the historical period of time in which they transitioned. Transition starts at the point in which a person stops living in the role assigned to them at birth and starts living permanently and completely in their preferred gender role. It is often the day when a person enters their work place in their preferred gender. Transition is seen as completed when a person has completed all the treatment (including completing their choice of trans-related medical services), though in reality this point in time is not necessarily the point at which they feel fully comfortable in their new role – that can often take far longer.

[53] See the European Commission website Eurostat **http://epp.eurostat.ec.europa.eu**.

Chart 4: The Current Age Distribution of the Respondents

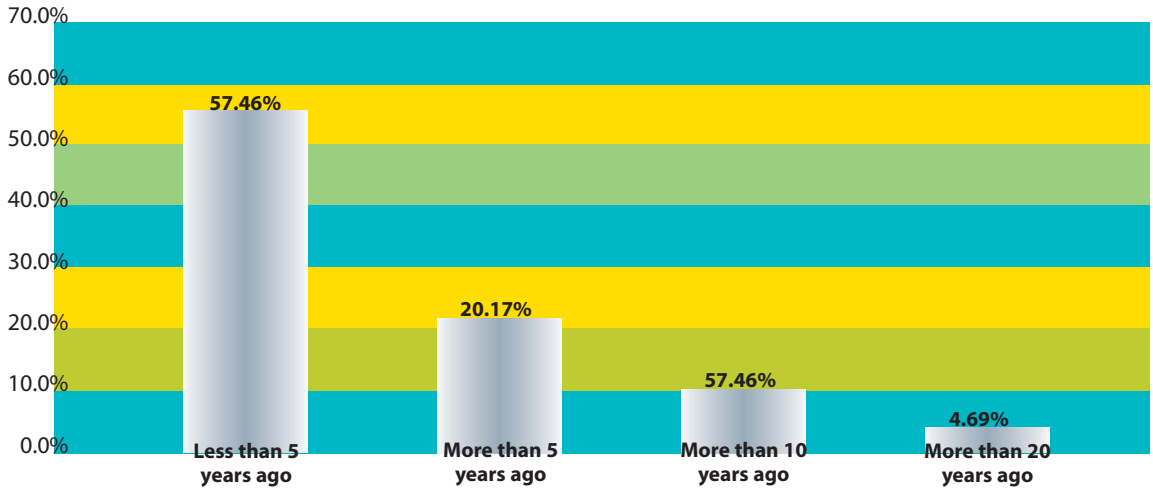


There is a normative population curve for the respondents profile, however its median value is higher, at 38, than that of a usual population curve of adults at 36-40.

Age of Transition: The age that people were when they transitioned was predominately in the 21st century (see Chart 5). There are several factors which may have influenced trans people wanting to actively seek out medical solutions to their personal feelings: the increasing recognition of transgender and transsexualism as an individual social problem that can impact considerably on a person's well being, alongside the growth in awareness of some people that transition might be possible for them. Also the increasing social awareness, amongst some, that trans people, even if not ordinary are not 'dangerous'. And clearly for there to be the options for people increasingly to transition, there is recognition that relief through the use of medical solutions such as hormone therapy and surgery can (and maybe should) be afforded. Moreover it very likely shows the increasing impact of trans social support groups as well as trans activists in communicating the message that there is help, and there can be rights. One very strong factor will be the growth of internet use and the facility to form online virtual communities.[54]

[54] For a detailed discussion on how the internet has mobilised trans activism and community networking, see Whittle (1998).

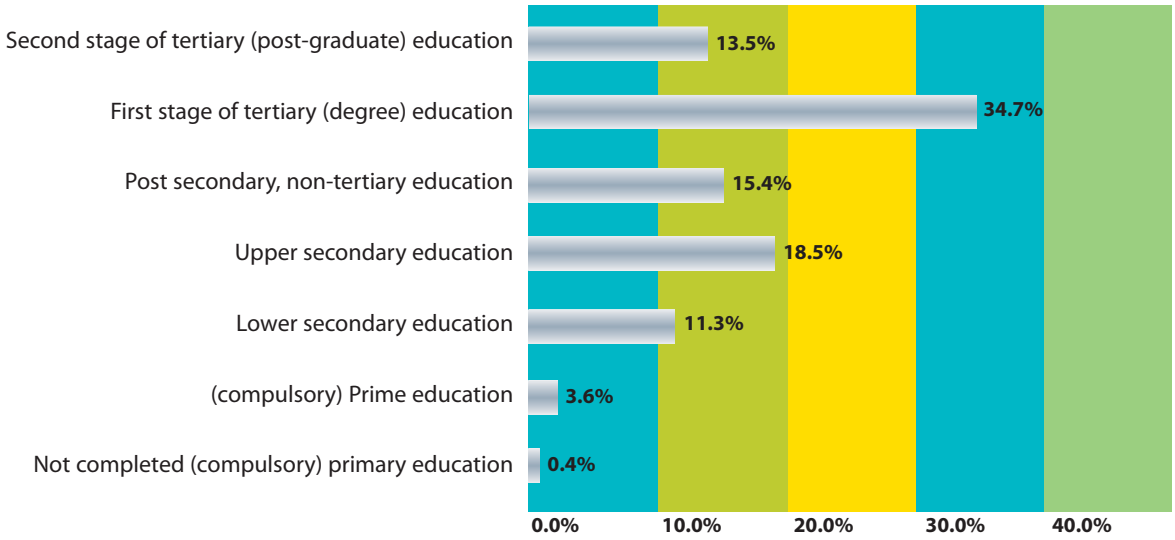
Chart 5: The Historical Period in Which the Respondents Transitioned



What we can also surmise from the figures in Chart 5 is that even though the age at which people transition varies, the population is predominately a 'young' population in 'trans' years, and there may well not be enough community 'elders' able to help and advise others as to how to access health care or any other service.

Education: The respondents' educational experience was not representative of the population and this is significant. Almost all (82%) completed compulsory secondary education, a little higher rate than the 2006 EU 25 figure of 77.7% (Eurostat). At the top end the achievement level is very high with 48.2% achieving a degree or post-graduate qualification, compared with high national averages of 27-30%.[55] There were also significant findings in the chart at the end of Upper Secondary Education, indicating a large number withdrawing from schooling at this stage. This very much mirrors the figures we obtained in the UK study in 2006 (Whittle, Turner *et al*, 2007), and needs further investigation.

Chart 6: The Educational Level Reached by the Respondents



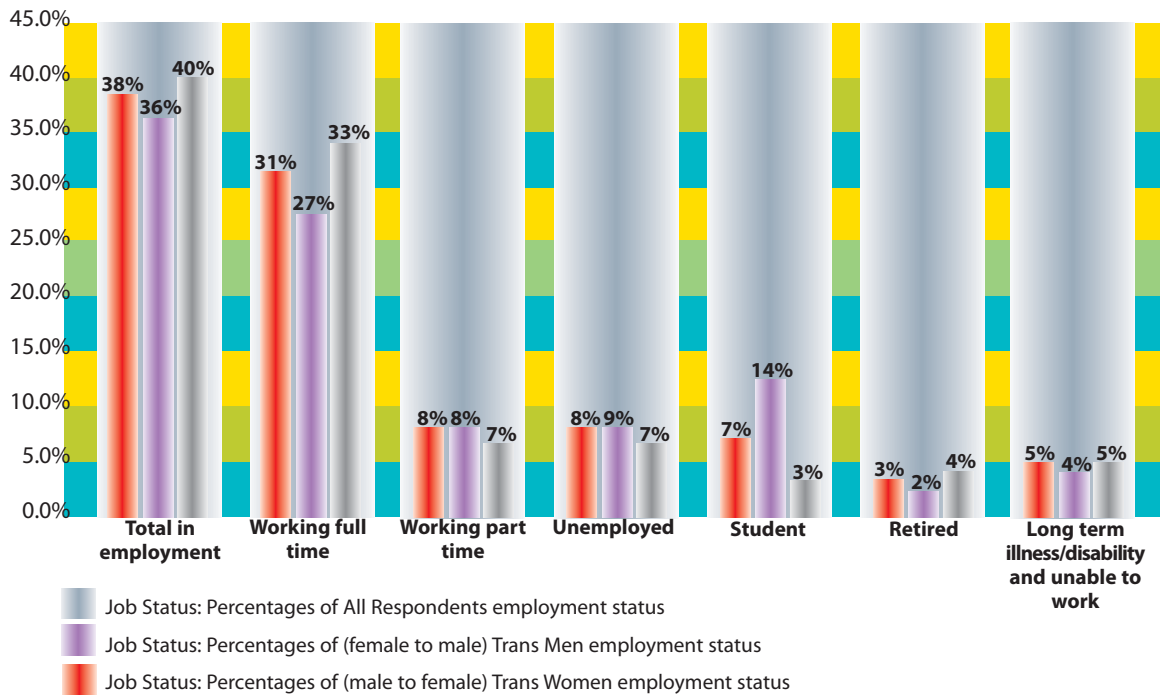
[55] See the European Commission website Eurostat **http://epp.eurostat.ec.europa.eu**.

Employment Status: Chart 7 shows that over the full European survey, unemployment figures appear favourable compared to the current European worker experience, with figures of between 5% (trans men) and 7% (trans women) compared to an EU 27 average of 8.2%, with the low end at 3.3% [Denmark] and the high at 10.2% (Germany).[56]

Despite this, the numbers in paid employment are low. The current EU 27 average for all those working out of the potential working population is 64.7%, with a rate of 57.4% for women, and 72% for men (Eurostat), whereas in the respondent population only 40% of trans women and 36% of trans men are in some sort of paid employment.[57] We can guess that this community is not generally a wealthy community, with an average of 31% in full time work.

In most European Union countries, protection in employment for trans people only came into existence with the decision of the European Court of Justice in *P v S and Cornwall County Council (P v S)*.[58] A few countries had provided protection earlier than the decision e.g. Netherlands and Germany, but the vast majority did not. Despite the very speedy reaction of the UK's tribunal system to this case, probably because it was a UK case, and the eventual introduction of regulatory protection,[59] we still see most EU countries, to date, having failed to formally extend legislative employment protection to trans people, relying instead on their lower court and tribunal systems to deal with claims that might arise. This may explain the statistics from this research report.

Chart 7: The Employment Status of the Respondents Across Europe



Salary and Wages: The respondents report a wide range of incomes, though they are disproportionately at the lower end of salary levels, with over one third – 37.4% – having a personal income of less than €20,000 per annum. Moreover, approximately half of trans people – 49.4% – have earnings less than €25,000, which is significant given that average earnings in the EU 27 are €28,000.[60]

[56] Source: Eurostat 18-12-2007

[57] See the European Commission website Eurostat **http://epp.eurostat.ec.europa.eu**.

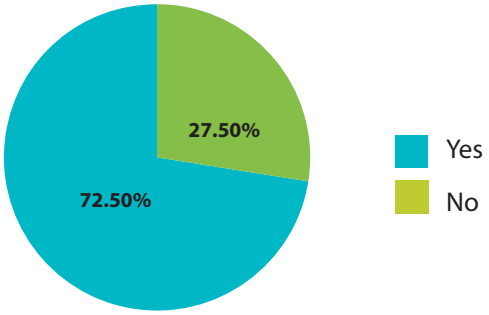
[58] *P v S and Cornwall County Council* (Case C-13/94) [1996], IRLR 347. In that decision the court clearly stated that: "In view of the objective pursued by Council Directive 76/207/EEC of 9 February 1976 on the implementation of the principle of equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions, Article 5(1) of the Directive precludes dismissal of a transsexual for a reason related to a gender reassignment."

[59] Sex Discrimination (Gender Reassignment) Regulations 1999.

[60] See the European Commission website Eurostat **http://epp.eurostat.ec.europa.eu**.

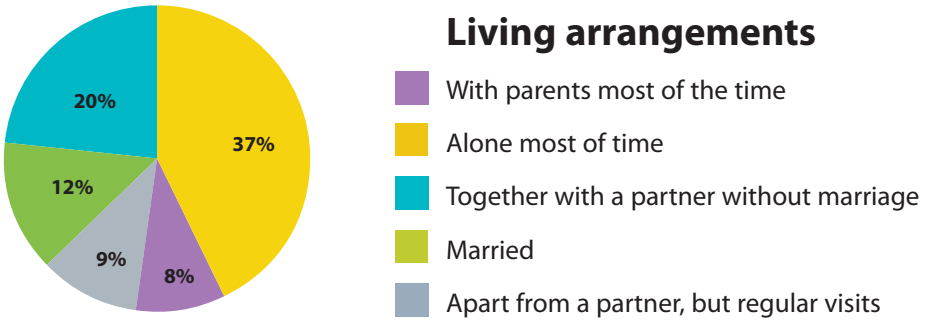
Undergoing Transgender Healthcare: As we have seen, the majority of respondents transitioned in the last 5 years and this means that medical treatments have also been sought in that time. Almost 1 in 4 respondents first accessed gender reassignment treatments in the last five years, explaining the increasing pressure on what is often, already, an undervalued part of the hospital team.

Chart 8: The Proportion of Respondents Who First Accessed Their Trans Health Care in the Period 2002-2007



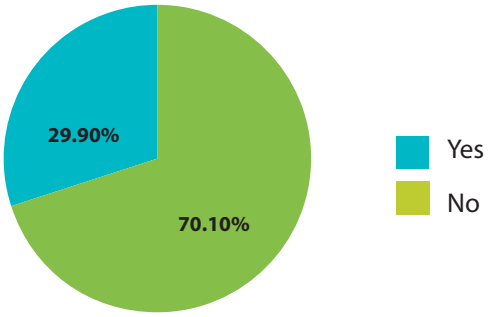
Living Arrangements: Chart 10 shows the family arrangements (or not) in which the respondents currently live. A far higher proportion [37%] live alone compared to the general population and only 12% are in a married relationship but 41% do have a partner, married or not.

Chart 9: The Living Arrangements of the Respondents



How Bad Can Life get?

Chart 10: The Proportion of Respondents Who Reported Attempting Suicide as an Adult



In the 2006 study for the UK the figures for the suicide attempts both for trans people as children and adolescents and for adults were identical: 34%, which needs further analysis and research. The European study figures are not much better than the UK figures, as can be seen in Chart 11. At 29.9% they are lower but not much. This is significant when compared with results of a large retrospective study of over 17,000 adults who attended a San Diego primary care clinic which found that the lifetime prevalence of having at least 1 suicide attempt was nearly an eighth the rate of our study at only 3.8%. (Shanta R. Dube, MPH; et al 2001). The San Diego study also related the question to those with adverse childhood experiences in any category. This increased the risk of attempted suicide by 2 to 5 times. Thus between 7.6% and 19% of the group had attempted suicide at least once, a figure at the top level of which is only 65% of the reported rate of these respondents.

Trans People Accessing Healthcare

There is very little published research concerning the issues facing trans people when accessing healthcare in the EU but from the available research it is clear that the issues facing trans people in accessing good quality healthcare are markedly similar from country to country. The second problem in terms of the paucity of research is that much of the research conducted subsumes trans people under the umbrella of 'LGBT' or 'GLBT' (for example The Medical Foundation 1997; Clark et al 2001), where data on trans issues is regrettably acknowledged as not available (Bell 2002; Quinn 2006). Some of the barriers for trans people accessing healthcare discussed below are similar to the LGBT community – for example lack of awareness by healthcare providers of the needs of these communities. There are, however, issues which are trans–specific which may not be addressed while under the 'LGBT/GLBT' umbrella – LGB people, for example, do not require a diagnosis from a medical professional in order to realise their identities. Moreover, the disadvantage of trans being incorporated under this 'umbrella' is that it may paradoxically maintain the erroneous view held by some practitioners that trans is an extreme form of homosexuality (as evidenced by Solymar 2006).

The available research on the issues for trans people accessing healthcare focusses on the barriers experienced by trans people. These are access to health insurance; the type and quality of provision of trans-related healthcare in one country; the knowledge and the skills of practitioners on trans-specific clinical healthcare needs; as well as awareness and understanding of trans issues in general.

It is documented that the treatment of gender dysphoria through gender reassignment has a very successful outcome in terms of quality of life. It is generally agreed by professionals working in the field that gender dysphoria cannot be alleviated by psychiatric treatment – for example drugs or therapy. The most comprehensive review of gender reassignment spanning over 30 years, 13 countries and over 2000 patients concluded that gender reassignment treatment was generally effective in relieving gender dysphoria, and that its positive results greatly outweighed any negative consequences gender reassignment yielded for patients with gender dysphoria (Pflafflin and Junge 1998). Pfafflin and Junge looked at the specific beneficial effects of gender reassignment in four areas: subjective satisfaction, mental stability, socio-economic functioning, and partnership and sexual experience. The most important area they identified was subjective satisfaction, which they noted was a demonstrated outcome in all the studies they reviewed.

Studies on the quality of life of trans people undergoing treatment have also found that early diagnosis and intervention do reduce the symptoms and increase quality of life (Nakane and Ozawa 2005) in particular the first stage – hormone treatment (Newfield *et al* 2006). Yet, the research on trans issues and access to healthcare suggests that much healthcare provision fails in the treatment of trans

people at the first point of contact, as much of the medical profession are uninformed or badly informed about gender identity issues (Scottish Needs Assessment 2001; Sperber *et al* 2005; Solymar 2006) and are not forthcoming in prescribing hormone treatment (Oriel 2000). This suggests that despite all the evidence of the success of gender reassignment in terms of improvement in quality of life and successful outcome, trans people are being let down by access to treatment.

The most recent qualitative and quantitative study on the issues facing trans people accessing healthcare was conducted in the UK (Whittle, Turner and Al-Ami 2007). This research found that many trans people were failed by the healthcare system when initially seeking help about gender dysphoria (usually a doctor). In an online survey completed by over 800 respondents, 60% stated that their doctor wanted to help but lacked information and some 6% refused to help. The survey also found that 29% felt that being trans adversely affected the way they were treated by healthcare professionals. These findings match qualitative research by Sperber *et al* (2005) which found that some health providers refused to treat trans people in a healthcare sector where 'ignorance, insensitivity and discrimination appear to be the norm' (2005: 75).

In terms of gaining funding for treatment, Whittle *et al* (2007) found that some 27% experienced difficulty and/or were refused or made to wait far longer than 6 months after referral from GP for initial assessment for possible gender reassignment. These findings also echo those of Solymar *et al* (2006) on health care access in Hungary which found that there was lack of professional expertise in the area of trans health, lack of regulation and diverse and difficult pathways to funding for treatment. Indeed, as stated earlier, access to funding is a clear barrier to treatment and a recent study suggested that EU countries with no health insurance for the treatment of gender variance had a markedly lower prevalence of people seeking trans-related healthcare (Gil *et al* 2006). Given the quality of life indicators for those who do gain access to treatment discussed earlier, funding is a significant factor in terms of trans people's getting their health needs met.

Other barriers to accessing healthcare which are not as concrete as obtaining funding, or lack of expertise by healthcare professionals on appropriate treatment, are the relationship between healthcare professionals and members of the trans population. A common finding in much research cites the stigma of gender variance coupled with fear of discrimination as preventing or significantly delaying people seeking help from professionals (Clark *et al* 2001; Feldman and Goldberg 2006; Quinn 2006; Bell 2002). From previous research then, it is clear that two themes are consistently emerging from research: the issue of access to funding for treatment and access to practitioners knowledgeable in trans-related healthcare.

The Research Findings

This section is divided into two areas of data analysis from the survey and the focus groups: the first covers clinical need and the second experiences of treatment by healthcare professionals. We analysed the survey findings using an 'Acceptable Baseline' (AB) 'benchmark' measurement for answers. Many questions were multiple choice and selected responses were coded as Acceptable Baseline (AB) responses. These were the bare minimum standard of treatment that trans people should expect to receive. The baselines were not ambitious, but were realistic expectations given the clinical need of trans people and acceptable treatment of patients by health care professionals.

Clinical Need Met

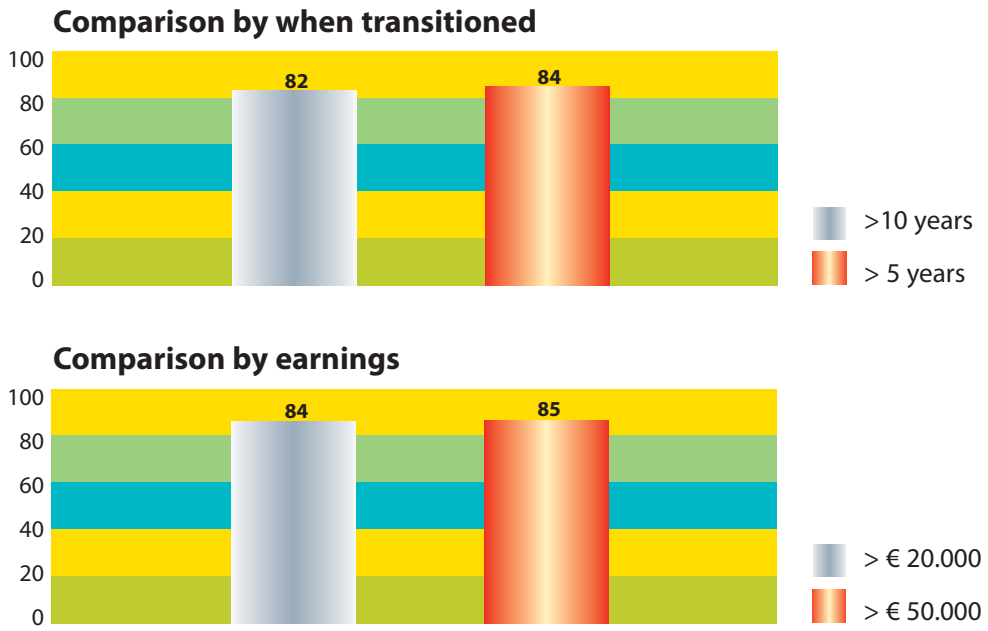
Using the 'benchmark' system three questions from the survey were analysed which covered the most basic clinical need of trans people.[61] These questions asked about access to State funding for hormones; access to State funding for surgery and being referred for appropriate treatment by a healthcare practitioner.

The responses to the survey were then compared across different groups. In the first group were those who transitioned less than 5 years ago compared with those who transitioned more than 10 years ago to determine whether treatment had improved. The second group was a comparison between those who earned less than €20,000 per year and those who earned more than €50,000 per year, in order to determine if those on higher incomes, who presumably might have more choices in accessing healthcare, had a better experience. The third group was a comparison between those who were in skilled occupations compared with those who were in unskilled occupations on the assumption that those who were in skilled occupations might have access to more choices in healthcare.

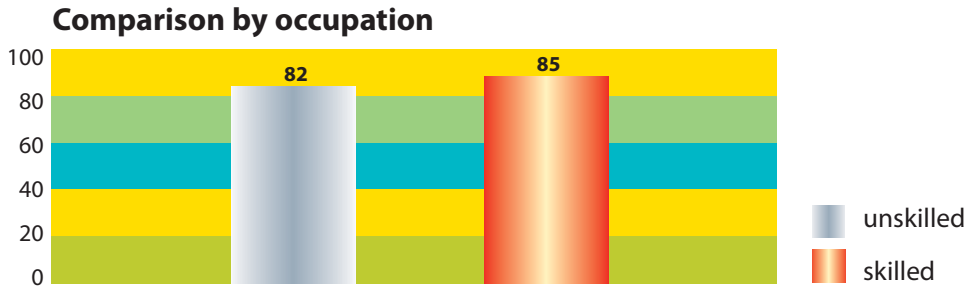
State Funding for Hormones

We asked respondents if they had been refused State funding for hormones, with the Acceptable Baseline (AB) benchmark answer as 'no'. The charts below represent those who did not get the AB.

Chart 11: Percentage of Respondents Who Were Refused State Funding for Hormones



[61] World Professional Association for Transgender Health, 2001, the Harry Benjamin International Standards of Care vers. 6, Minnesota: WPATH.



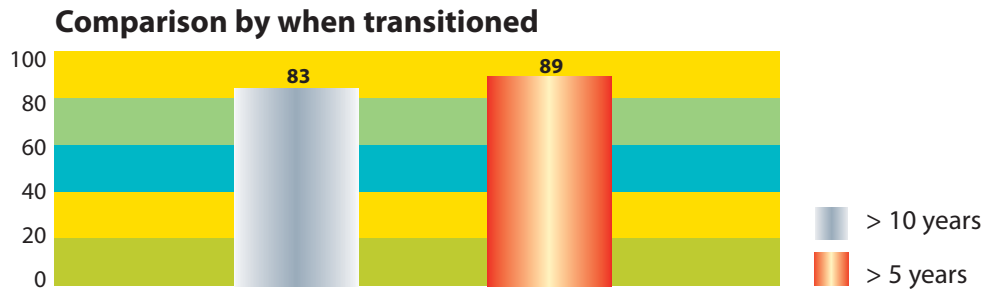
We can see from Chart 12 that the vast majority of respondents were refused State funding for hormones, with more respondents who transitioned less than 5 years ago being refused than those who transitioned more than 10 years ago. This is a worrying finding as the assumption would be that access to funding for treatment would be improving.

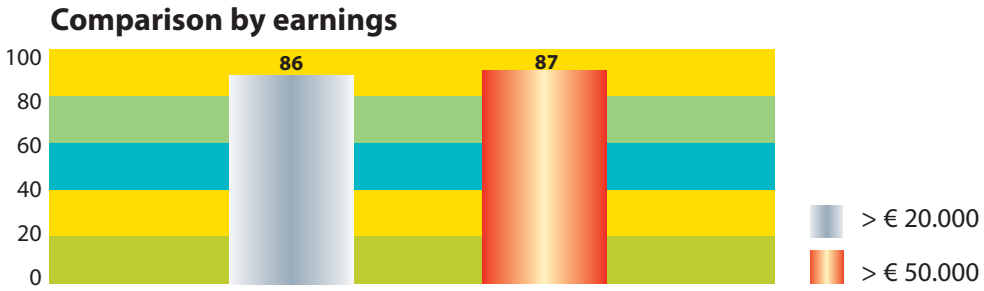
A slightly higher percentage of those in skilled occupations reported a refusal than those in unskilled occupations and there was only a minor improvement of 5% for those who were on an income of €50,000 or more. These findings demonstrate that access to funding for hormones affects trans people across the income and occupational spectrum.

State Funding for Surgery

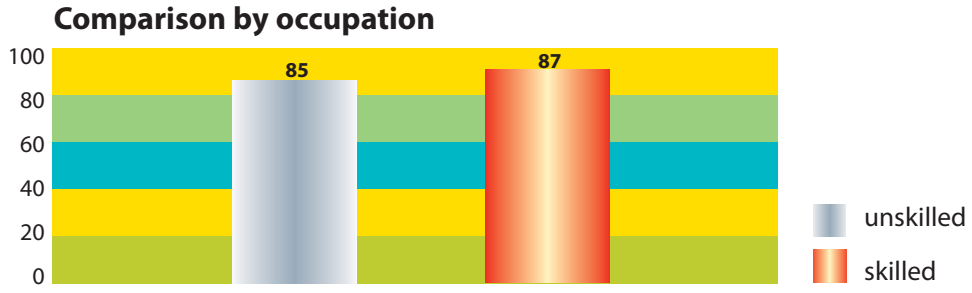
The second question was concerned with State funding for AB surgeries. These were the minimum acceptable surgeries that the research team agreed were required for trans people to live in their acquired gender.[62] For FTMs this was Mastectomy and MTFs this was Vaginoplasty.

Chart 12: Percentage of Respondents Who Were Refused State Funding for AB Surgery





[62] These Acceptable Baselines were not easy to determine. Not all trans people want surgery and some trans people feel that they need to have all the surgery possible in order to live their lives to the full in their acquired gender. The decisions for ABs were based on knowledge of the primary surgeries that MTFs and FTMs need in order to begin living more comfortably in their acquired gender.

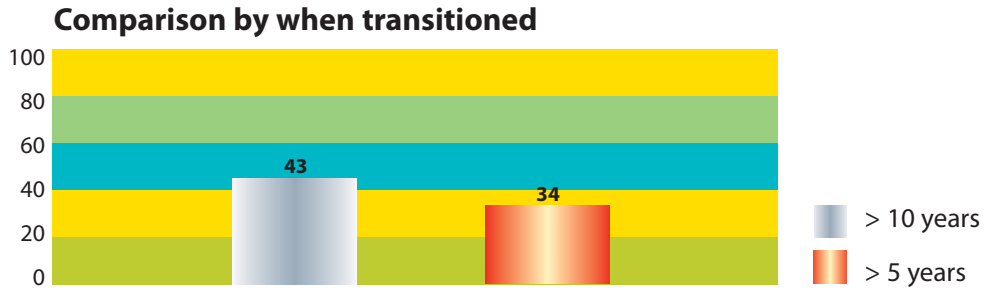


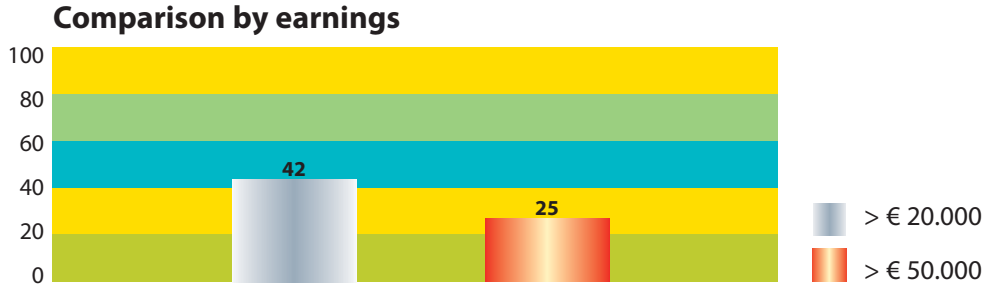
Like the previous analysis, the percentages of respondents being refused State funding for AB surgeries is very high. We can see that the situation regarding access to State funding for surgery may be worsening, with 6% more respondents who transitioned less than 5 years ago being refused than those who transitioned more than 10 years ago. We can also see that across the income and occupational spectrum, the difference in access to State funding for surgery is minimal.

Refused Treatment

The third question was concerned with being refused treatment because a healthcare practitioner did not approve of gender reassignment. The AB answer was 'no'.

Chart 13: Percentage of Respondents Who Were Refused Treatment Because a Healthcare Practitioner Did Not Approve of Gender Reassignment





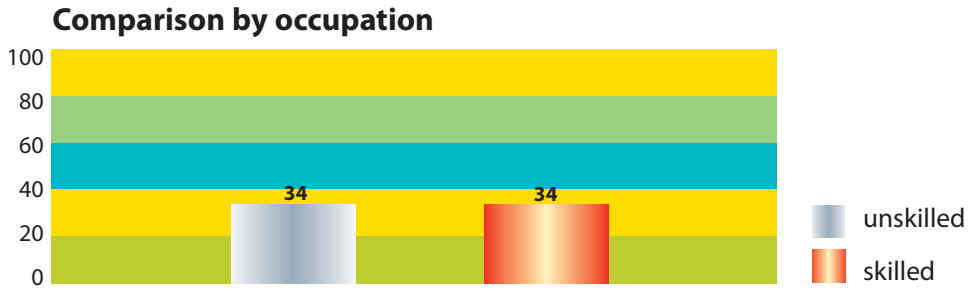


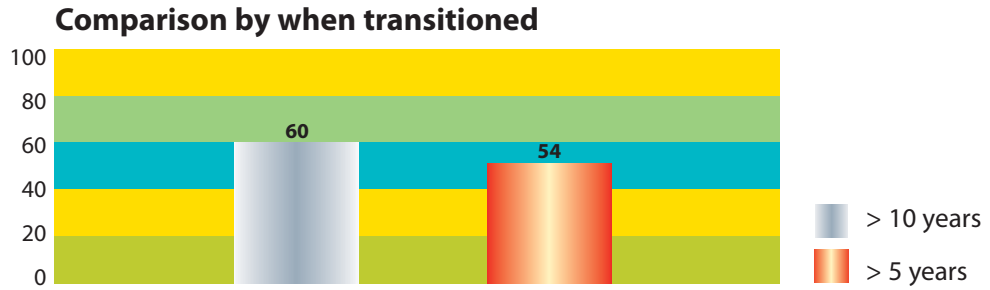
Chart 14 shows that nearly one third of the respondents from all the selected groups are reporting that they were refused treatment because a practitioner did not approve of gender reassignment. There is also only an improvement of 9% for the respondents who transitioned less than 5 years ago. There is no difference at all between those who were in skilled or unskilled occupations, but a difference of 17% in the comparisons across salaries, with a markedly smaller number of those on a higher income reporting a refusal.

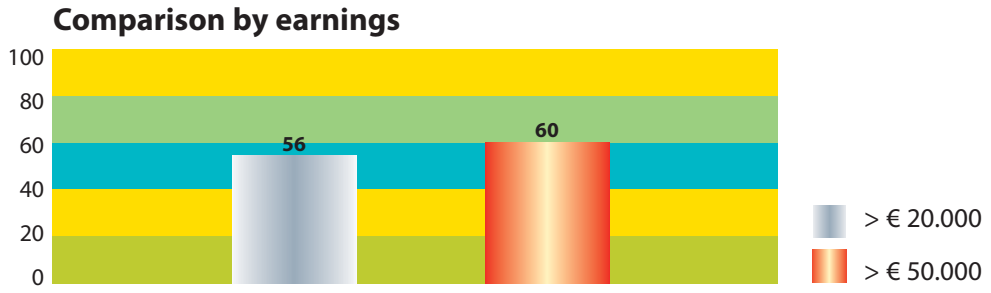
A survey respondent in Italy wrote:
My GP stopped writing my prescriptions (not hormones) and advised me to find another doctor because he didn't approve of my transition.

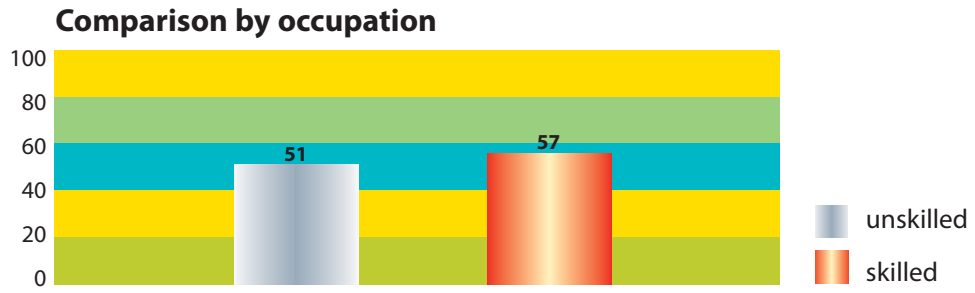
Further Analysis of Those Who Were Refused Who Paid for Treatment Themselves

We asked respondents if they had ever been refused, or made to wait far longer than expected, for any treatment relating to transgender or transsexual health care, including gender reassignment, after appropriate clinical recommendation. We then added a filter to determine those who had been refused and then paid themselves. This filter was applied across the different groups.

Chart 14: Percentage of Respondents Who Were Refused Treatment and Paid Themselves







These figures in Chart 15 show that over half of all groups were refused funding and paid themselves. What is surprising in these results is that, although there is a minor difference of 6% between those who transitioned less than 5 years ago compared to those who transitioned more than 10 years ago, there is very little difference between those who were in the low income bracket and those in a higher income bracket who paid for their treatment themselves. This factor is particularly concerning if we take into account our finding that nearly half of all respondents were in the lower income bracket of less than €25,000 per year and the financial burden that paying for surgery must have been.

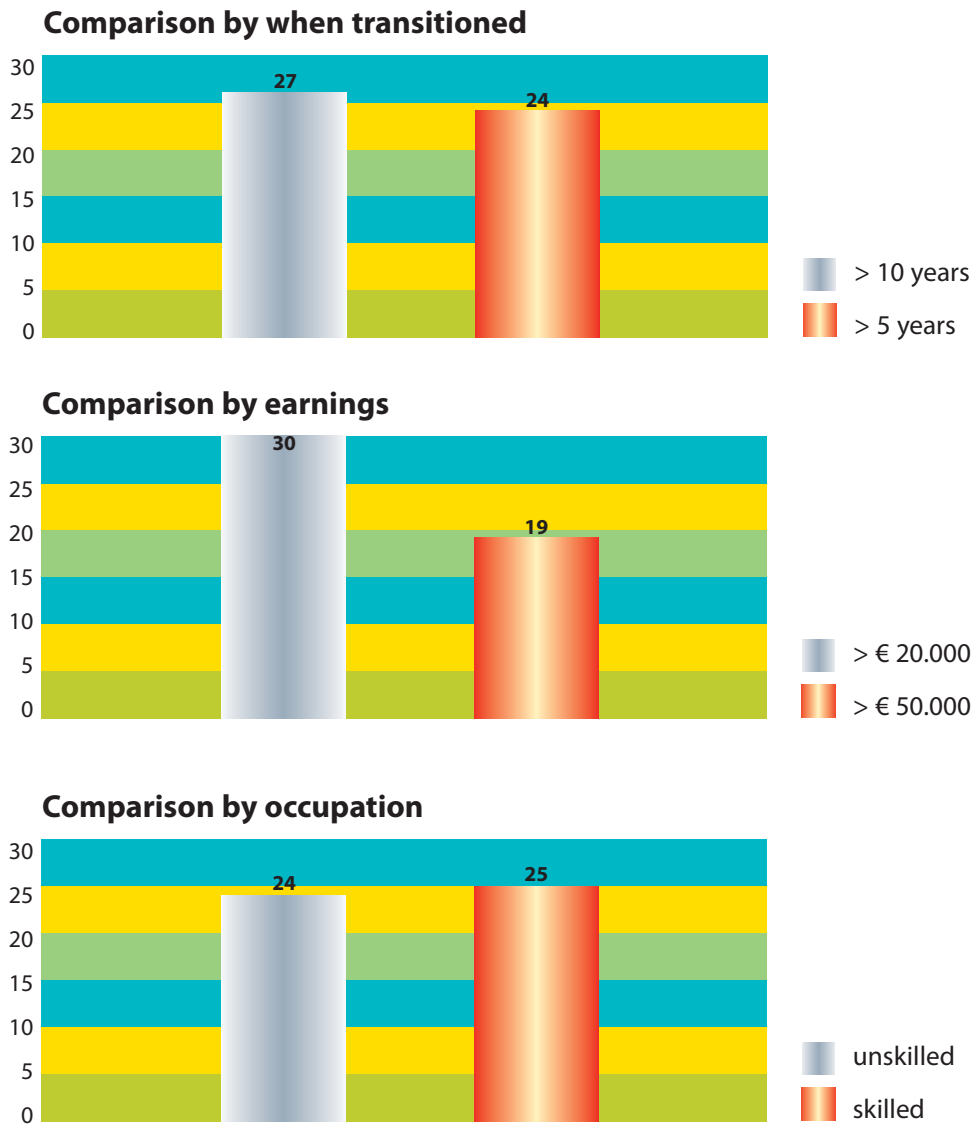
Treatment by Healthcare Professionals

This second section of the data analysis employed comparison of the same groups - those who transitioned less than 5 years ago compared with those who transitioned more than 10 years ago; a comparison between those who earned less than €20,000 per year and those who earned more than €50,000 per year and a comparison between those who were in skilled occupations compared with those who were in unskilled occupations. The questions asked were concerned with trans people's experiences with healthcare professionals as previous research has shown that this is a problematic area in terms of the knowledge that they have of trans-related treatment as well as personal attitudes that some practitioners might have about gender reassignment.

Responses by Healthcare Professionals when Treatment was Requested

The first question concerned the first healthcare professional who might be approached when a trans person seeks gender reassignment – a doctor or psychiatrist. The question was 'when you first talked to a doctor or psychiatrist about your transition how did they respond? The AB answer was 'wanted to help but lacked information'.[63] The Best Practice (BP) was 'they were informative and helpful'.

Chart 15: Percentage of Respondents Who Did Not Get an AB Response from Doctors or Psychiatrists Regarding Their Gender Transition



[63] This may seem like a very generous AB, but we feel that it is a realistic one as the majority of healthcare professionals have no knowledge about trans-related healthcare. The question was concerned with ascertaining whether there was good will to help the trans patient.

We can see from the data in Chart 16 that approximately one quarter of all respondents across the groups and categories did not get an AB response when seeking treatment. There is little difference between those who transitioned less than 5 years ago and more than 10 years ago – indeed the responses from healthcare professionals appear to be getting worse. What is noticeable is the

difference between those in the low earnings and high earnings group, with nearly one third of those in the lower income bracket reporting no AB response, compared with 19% of the higher income bracket group. The difference between occupations is also negligible. The acceptable baseline we used was very generous – a practitioner wanting to help but lacking information, which is the minimum one should expect for a patient requiring specialist help.

Accessing Non Trans-related Healthcare

The second question concerned the way that being trans may affect the ways that trans people access routine non trans-related healthcare. This might be an anticipated reaction from practitioners which may be based on previous experience. The AB answer was 'no'

Chart 16: Percentage of Respondents Who Feel that Being Trans Affects the Way that They Access Non Trans-related Healthcare

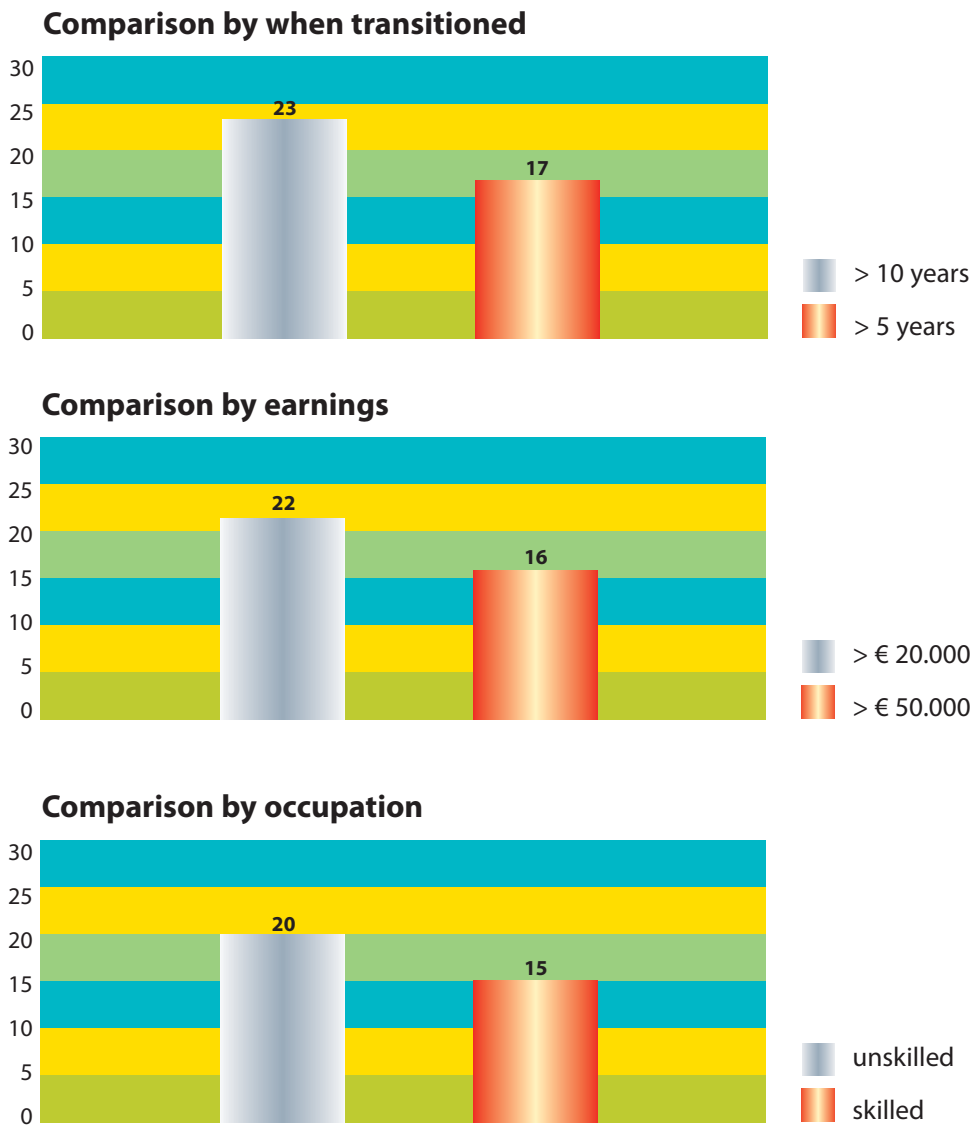


Chart 16 evidences a slight improvement in accessing non trans-related healthcare for those who transitioned less than 5 years ago, with a difference of 6% from those who transitioned more than

10 years ago. There is also a 6% difference between those on higher incomes when compared to the lower income group, as well as a 5% difference between the skilled and unskilled group.

The narratives from the focus group and survey suggested that trans people avoid accessing routine healthcare because they anticipated prejudicial treatment from healthcare professionals. Indeed, one translator from the French focus group reported that 'the theme of not daring to go see a doctor for any sort of care, even those unrelated to being trans, for fear of transphobia is a recurrent one for both FTMs and MTFs'.

A participant in the Austrian focus group said:
I don't see the doctor if I don't really have to. I don't see the dentist, I don't see the gynaecologist, since decades, and if I have an accident, I try not to go to the hospital... I think I have less experiences because I just don't go there, so I practise some kind of avoidance strategy.

A participant in the focus group in Italy said:
…when I go to use health services I myself am on guard, like, what will they say to me, what will happen, will they accept me, in which section are they going to put me? So, all these fears, influence my ability to access health care, so often, I've avoided going, use health care services, exactly to avoid these fears, paranoia.

And a French survey respondent wrote:
…it is not easy for me to go see a doctor for fear of his/her potential transphobic reactions.

Thus, trans people are avoiding accessing routine treatment from health care professionals for fear of an adverse reaction to being trans from healthcare professionals.

Another theme that emerged out of the narratives from the survey and focus groups which also may be an explanation of the previous responses is the pathologisation of trans people, due to it being classified with mental health conditions.

One Finnish survey respondent wrote:
As a trans person I have been labelled with a negative stigma of a mental patient by some health care personnel.

A focus group participant in France said:
It is absolutely necessary that transsexualism should be removed from the list of mental illnesses because we constantly feel obliged to justify ourselves to the health professionals.

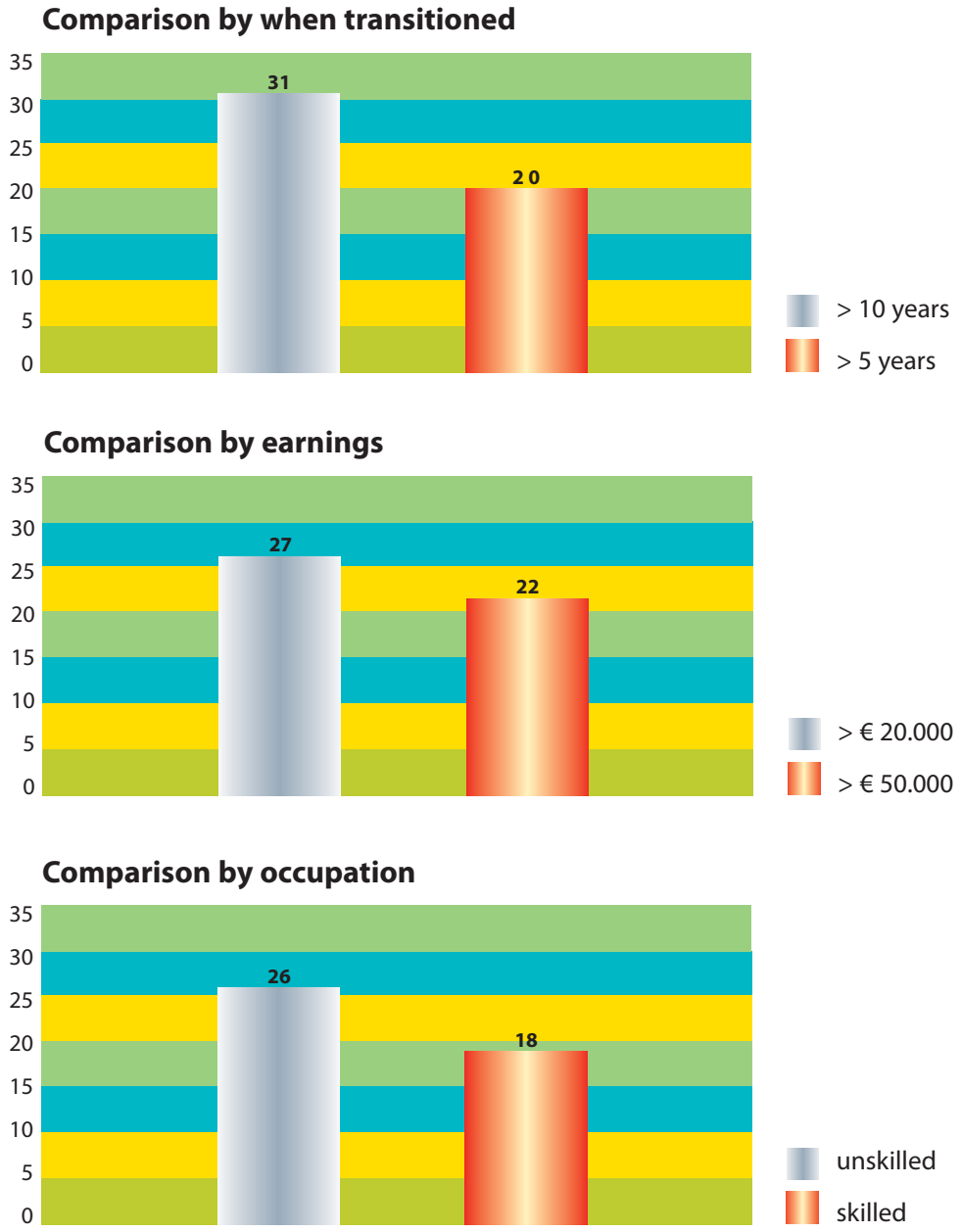
A Dutch survey respondent wrote:
I often have the feeling that health care professionals do not take me seriously because of my trans identity and see me as a psychiatric case.

Trans people then anticipate a negative response from healthcare professionals when accessing non trans-related healthcare, which may be linked to the classification of trans as a mental illness.

How Being Trans Impacted Treatment by Healthcare Professionals

The third question concerned experiences of actual treatment by healthcare professionals. We asked respondents if they felt that being trans adversely affects the way that they were treated by healthcare professionals, with the AB being 'no'.

Chart 17: Percentage of Respondents Who Felt that Being Trans Adversely Affected the Way They Were Treated by Healthcare Professionals.



We can see in the data in Chart 17 that approximately a quarter of the respondents across the groups experienced adverse treatment by healthcare professionals because they were trans. There is a difference of 11% between those who transitioned less than 5 years ago compared with those who

transitioned more than 10 years ago, which suggests an improvement in treatment – or that those who transitioned a shorter period of time ago have had less experience with healthcare professionals. We can also see that those on lower incomes or who are in unskilled positions have had worse experiences than those on higher incomes or who are in skilled positions.

This section of research is the most supported by the narratives from the focus groups and survey. The most consistent theme from the narratives in the qualitative research was that of improper or abusive treatment by healthcare professionals.

> A trans woman in the French focus group said:
> *After the surgery, every time the surgeon would come, there was a bunch of students with him, and he would always say: 'Here is the case of Mr Philippe B.' (…) On the second day, the urinary probe slipped out. It would have taken more than that to ruffle him: he took a fresh one and just stuck it back up into me without anaesthesia or anything.*
>
> A Dutch focus group participant said:
> *Everything went fine until I started to interfere with the policy of my psychologist. He wanted me to take part in some sort of research. I asked him what the scientific relevance was and questioned whether the research was relevant to me. He got angry and destroyed a letter in which he had just written down that I was eligible to start hormones. He tore the letter in front of my eyes.*
>
> A participant in the Hungarian focus group said:
> *After the operation, I was transferred to the [incorrect gender] ward. I was subjected to very unpleasant and inhumane treatment. They stripped me naked for an examination in front of the whole ward so that they had a chance to see a transsexual patient.*
>
> A respondent (trans woman) to the Italian survey wrote:
> *Even though the hospital that I go to for hormone therapy knows about my gender identity, they continue to refer to me with the masculine gender, even in front of other patients. One time, after a blood test, I overheard two nurses who were laughing at me.*

These findings closely match the narratives of previous research in the UK, where 29% of respondents felt that being trans affected the way they were treated by healthcare professionals. Previous research has shown that a relationship of mistrust between health care professionals and trans people means that even when accessing care, some trans people withhold personal information which may be relevant to their health (GLBT Health Access Project 1999). Research by the Medical Foundation in the US found that healthcare providers lack the skills and knowledge to respond to trans people's needs and that 'fear of rejection and ridicule keep many transgender people from seeking medical and mental health care' (1997: 41).

Many of the studies strongly emphasise the need for training of healthcare professionals in the needs of trans people. Indeed, an exploratory study of the training needs of healthcare professionals found that there was a desire by some service providers to treat trans people in a respectful way but they were restricted by a lack of information about the trans population and lack of treatment guidelines (and access to them) (Lurie 2005). Two themes consistently emerge from the recommendations in much research literature; the need for community based clinicians and for

training in cultural competence on the needs of trans people.

It has been suggested that centralised institutional-based systems of healthcare for trans people offer a poor standard of care for trans patients and that community-based clinicians, particularly if they can be trained in core competencies can provide a good service to trans people (Goldberg 2006; Scottish Needs Assessment Programme 2001). Indeed, many of the findings above, in particular the narratives about improper treatment suggest that many practitioners in centralised trans-related healthcare provision have power and control over trans people that might be used inappropriately. In short then, the best model of treatment would be trans-specific clinics with regulated clear care pathways and 'transpositive' (Solymar 2006) where clinicians have received advanced training in trans issues (Nemoto 2005).

The GLBT Health Access project in Massachusetts (1999) has developed Community Standards of Practice to provide a benchmark for healthcare providers and users, which is comprehensive and far-reaching. It includes policies and practices which prohibit discrimination, with an emphasis on cultural competencies (appropriate language; familiarity with LGBT issues; community relations and outreach etc.). From the evidence above, it is clear that many of the problems that trans people face accessing good quality care could be improved by the training of healthcare providers.

Conclusion

The data from this research shows that regardless of earnings and social status, the healthcare treatment for trans people currently being provided in their countries is very poor. In terms of clinical need, a high majority of respondents are not getting State funding for hormones and primary baseline surgeries. Nearly one third were refused treatment because a healthcare practitioner did not approve of gender reassignment. More than half of the groups at both ends of our occupational and earnings spectrum are paying for surgery themselves after being refused State funding. Given that nearly half of all respondents are in the lower income bracket of less than €25,000 per year this is an onerous and unnecessary financial burden.

In terms of treatment of trans people by healthcare professionals, approximately one quarter of respondents seeking access to gender reassignment treatment did not get an acceptable response from a healthcare practitioner – they did not want to help. Given this, it is significant that the narratives from the focus groups and survey found that trans people avoid accessing routine healthcare because they anticipate prejudicial treatment from healthcare professionals. This corresponds with our finding that approximately a quarter of the respondents across the groups experienced adverse treatment by healthcare professionals because they were trans. There is strong evidence from the focus group and survey data that the link between seeking gender reassignment and mental illness is a strong factor in the (mis)treatment of trans people.

Gender Identity Disorder, the more medicalised name for being trans, is still recognised by the American Psychiatric Association as a disorder in the Diagnostic and Statistical Manual IV, and they approve of gender reassignment treatments, as no cure is known. The World Health Organization also recognises it as a disorder in the ICD10; to be treated by hormone therapies and surgery where appropriate.

The vast majority of health care trans people need is not related to their being transgender, yet as the survey and focus groups have shown even that health care is constantly compromised. In no other recognised medical field are doctors, nurses, and radiographers for example given such free range to insult and embarrass their patients.

Trans people are ordinary people who just happen to have a medical condition that needs

treatment, and medical treatments should be available to trans people unless there is some exceptional reason for not providing it. That is effectively what the Court of Appeal stated in 2006 in the case of *R v North West Lancashire Health Authority*.[64] As one might imagine after reading this report, even in the UK where the case was decided, the method of funding continues to turn this decision upside down so that trans people are only afforded treatment in exceptional circumstances rather than vice versa.

The principle of contemporary health care has always been to meet need on an equal basis, which includes creating parity by having some wealthier patients paying towards their costs and others getting it for free, rather than on a certain characteristic for example originally the colour of your skin or your gender, and now, your ethnicity, faith, age or sexual orientation. In theory, very recently,[65] with the implementation at national level of the Council Equal Treatment in Goods, and Services Directive 2004/113/EC of 13 December 2004, trans people who are intending to undergo, are undergoing or who have undergone gender reassignment[66] have to be offered equal treatment in the provision of health care as a service. Maybe this will promote change. However, the need for comparators in establishing the discriminatory treatment might have the effect of hiding gender reassignment treatments even further; with doctors and administrators saying the work they do cannot be compared with any other services, no matter how badly they do it. This is clearly not what is intended by the Directive. This problem will not disappear and indeed needs to be addressed given the exponential growth in the trans population that our data strongly suggests.

The Growth in the Trans Population

The data from the survey for this report also provides strong evidence that the trans population is growing year-on-year. The majority of respondents reported that they had transitioned less than 5 years ago. The data from our survey was plotted on a graph which demonstrates the exponential growth in the trans population for each time period we specified in the survey.

The Chart below shows a summary of the time for Europeans, now living full time in their preferred gender, reported to have elapsed since they began their transition; these results are also depicted (see figure 1). Figures are given for the whole group and for Female-to-Male (FTM) and Male-to-Female (MTF) categories separately. It can be seen that the number of people transitioning is now increasing rapidly throughout Europe.

Chart 1: Time Since Transition Reported November 2007

Time	Total	FTM	MTF
All	985	377	608
> 5 years	601	258	343
< 5 years	211	72	139
> 10 years	124	34	90
> 20 years	49	13	36

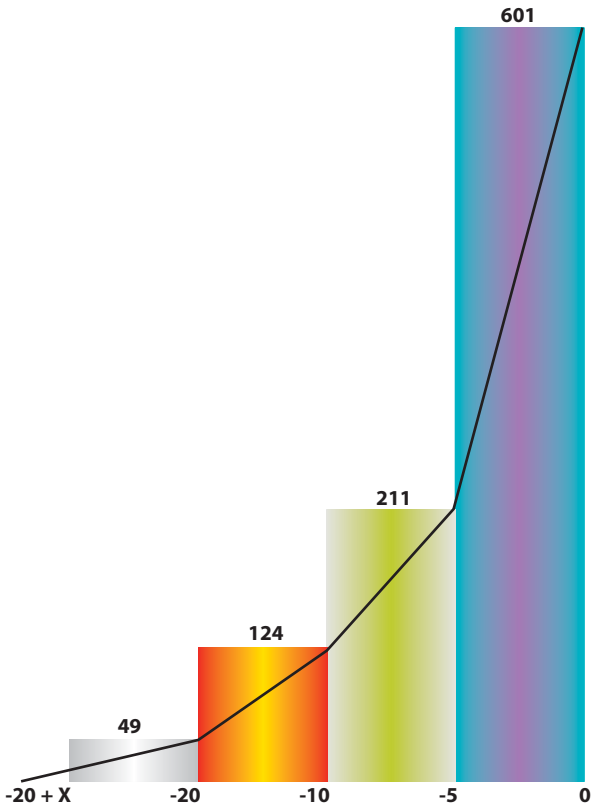
[64] R v North West Lancashire Health Authority; Ex parte A, D, G (2000) WLR 997.

[65] December 21, 2007.

[66] Which has been as loosely interpreted as meaning that the trans person merely visits their family doctor in order to think about it.

Figure 1: Plot of Transition Times Relative to Present Day

A smooth curve can be plotted on these results intersecting the abscissa at some unknown time 20 + x years in the past; a possible curve is shown by a black line superimposed on the figure.



It is quite clear to those working in the field that the trans population is growing as change has come about, and more and more people feel empowered to claim their trans identity at whatever cost. These changes have largely been led by the media, and specific points in media history have driven trans people to recognise themselves and claim their identity. It is a history from the first appearance of Christine Jorgenson's story in the New York Daily News in 1952, and the appearance of Jan Morris (a former Times reporter who had been with the team to first climb Everest) on BBC television in 1974 at the time of the publication of her memoir: Conundrum (Morris 1974), through the bleak years of the 1980s when trans people became terrified of the media hounding them to report 'sex motivated' stories, to the 1990s when the film 'The Decision', the first film study of (female to male) trans men including a 12 year old (daughter) son on a quest to seek the best treatment in Europe, was also shown on BBC television before being released throughout Europe. Those who work in support services have seen marked rises in enquiries at each of these times.[67]

Maybe it is a consequence of this that the growth in those trans people seeking support and medical services, appears to be on an exponential scale. But as we now see more and more media images of trans people on almost a nightly basis in some countries, for example Italy has several trans people fronting regular television shows, it may well be that the growth continues in this exponential way.

Whether there are really more trans people or whether there are more trans people 'coming out' is an important question. Is gender really being challenged? Or is it simply that more and more people

[67] Whittle, S., 1999 (unpublished research data).

wish to choose the gender they wish to live in, or perhaps more people feel able to be open about an essential aspect of their personality that has been repressed in previous generations? It may actually be that there are more trans people in contemporary cultures and societies; we will not know the actual answer until far more in-depth research is done. However, the growth illustrated clearly has implications for the provision of trans-related healthcare in the immediate future, and is a prompt to act now.

Solutions?

Increased European involvement in equality strategies for transgender and transsexual health could assist in the coordination of more effective service delivery across European countries. For example, as populations become increasingly mobile due to the changes in visa requirements within Europe and the effect of workforce globalisation, networks of trans people have developed across national boundaries. Knowledge of specialist services in different parts of Europe have come to light and many trans people have begun to access services beyond their local area, using the European Health Insurance card system, even when this means having surgical treatment outside of one's home country.

Service – a New Role in Health Care?

21 December 2007 was the transposition deadline for European Council Directive 2004/113/EC of 13 December 2004. The Directive implements the principle of equal treatment between men and women in the access to and supply of goods and services. It does not explicitly refer to trans people or to gender reassignment, but the minutes of the Council meeting include an explicit note that the directive should be interpreted in the light of the 1996 ruling by the European Court of Justice (ECJ) in *P v S and Cornwall County Council*[68], in which the ECJ held that the prohibition of discrimination on grounds of sex should be construed to include discrimination on grounds of gender reassignment. This means that a person should be protected from discrimination on the grounds that they are "intending to undergo, are undergoing, or have undergone gender reassignment" in the provision of goods and services. This includes all activities in the public and private sectors, whether paid for or not. Health care is not exempt, it is a service.

The rights contained within the Directive have existed since its publication in the European Official Journal in December 2004. As yet there has been no application to the European Court of Justice (ECJ) by a trans person using the Directive. Applying directly to the ECJ is very hard for the average person, but for low earners it is impossible due to the high cost of legal fees. Individuals would have to rely on community legal services, or have a case referred to the ECJ by a lower court. The fact that there has been no case in this period does not say anything about the quality of services trans people receive (or not), it has more to do with the question of cost and the lead in time to access the lower civil courts in the UK. In spite of this, as a service, health care providers and States will now be required to have knowledge of the law and to take an active role in preventing discrimination due to a person being trans.

In the UK's Equality Act 2006, an extra duty has also been imposed on public sector providers, which would include the National Health Service. The public sector in the UK now has to have a gender equality policy and strategy, and within that they must positively promote equality and diversity for trans people. Hypothetically, a European Directive requiring such a duty might well prompt States and providers in the public sector provision of health care to acknowledge the needs and rights of trans people and make an effort to equalise their access to personal health care.

[68] *P v S and Cornwall County Council* ECJ [1996] IRLR 347.

Proposals for Change

From the online survey data results it is possible to highlight several major concerns:

- The current shortage of accessible, localised, access to specialist care for transgender and transsexual people.
- That current service provision, even if accessible, generally provides a very poor experience for the trans person.
- Many current service providers need to take action so as to provide a regularized service that meets internationally recognised best practice (WPATH, 2001).
- The issue of the rights of trans people to dignity in healthcare.

It is currently impossible to police the sort of single but complex multi-layered health care issue which trans health is, within the many different European healthcare systems. At present, the few specialists in this area are unevenly distributed and are usually concentrated in urban Western Europe. Choice is often only available to those trans people with sufficient wealth to travel across borders and to seek out more than one consultation.

Access to specialist services should be made available to trans people in all areas, regardless of their local or national healthcare arrangements, or the individual's financial status. Cross-boundary coordination would be helpful as some countries do not have access to the most advanced treatment and would need to contract such services. Access could be made possible for those patients who are unable to receive services in their local area through an EU travel fund, as continuous substandard healthcare can have harmful social, psychological and economic effects for the individual.

Furthermore, as transgender and transsexual Europeans move from one area to another due to the freedom of movement afforded by EU citizenship, issues of continuity of care arise. Greater practitioner education is required so that trans people in all areas of Europe have access to quality treatment on a more equal basis and so that prejudice is reduced at all levels. Facilitating the exchange of knowledge for both practitioner and patient would be an ideal way for the European Union to promote higher levels of excellence and coordination.

An evaluation should be undertaken by each European country that will acknowledge and address the needs of trans people in healthcare. This should take place in partnership with relevant stakeholders: local transgender and transsexual communities, healthcare providers and healthcare funding decision makers. These evaluations should be used to develop action plans that will propose solutions to healthcare disparities and that will support further equalities work. Trans people require policies that acknowledge human differences whilst recognising the right to appropriate treatment without unnecessary delay. It is imperative that there is a top-down shift in the view that trans-related healthcare is cosmetic or elective, and the needs of this patient group must be prioritised in line with other important medical treatments.

There is also a clear need to move away from the view, as contained in Diagnostic and Statistical Manual (DSM) IV and International Classification of Diseases 10, that transgender and transsexual identities are the result of pathological mental illness. In order to reduce the stigma that currently exists another space within diagnostic structures needs to be found, for example within endocrinology or in surgery. This might seem impossible, when the main Diagnostic Consultative Committees of the American Psychiatric Association (APA, 1994) and the World Health Organisation (WHO, 1994) are still firmly embedded in the idea that to be trans is to suffer from mental disorder, even though they both

acknowledge there is no known cure, but that transgender medicine and surgery can alleviate a patient's distress and anxiety, and often enable them to regain a place in society. Though trans people have expressed their concerns repeatedly, and are currently lobbying the APA for a revision of the categorisation in the DSM V, there has yet to be seen a body of psychiatrists coming out on their side.

Trans people have a right under the European Convention on Human Rights not to be discriminated against and this would include access to anything that might prevent a loss of their rights to private and family life. Similarly a right exists under Community law to freedom of movement, which includes movement to access health care. A few Health Authorities in the UK have already funded (female to male) trans men to have surgery overseas in Belgium where the team at the University of Ghent Hospital are considered amongst the best for phalloplasty surgery. Similarly, trans men in The Netherlands and France also often seek surgical treatment in Belgium using their insurance coverage (Whittle *et al*, 2005). But these opportunities have rarely been taken up because they generally require the patients to meet travel costs and supplementary hospital costs which, for example, rebut the UK's NHS concept of free healthcare at the point of access. Trans people, who from the evidence of the data analysis for this report are almost all economically and socially disadvantaged for the transitional periods of their lives, are rarely able to meet the costs of taking up such opportunities.

One of the most frustrating aspects of the EU for trans people has been its failure to ensure that Member States are meeting their obligations under the directives, regulations, policies and case law. As one trans woman said:

> "who do they think we are, have they ever bothered to look at our demographic, do they not know we are poor and have very little spare cash for the luxuries in life such as justice?"[69]

Put simply, whatever is said in the meeting room is often blatantly ignored in the corridors. Since the ECJ decision of *P v S and Cornwall County Council* in 1996, no country other than the respondent country has taken action to ensure protection exists in the workplace. Without enforcement, and punishment if necessary, many States and employers will continue to ignore the EU legislations and the protection they offer to trans people.

As European citizens, it is now time for trans people to be considered fairly in healthcare which is a major part of the possibility of leading a successful life. National and European prioritisation needs to be given to finding new ways of meeting trans people's medical needs. Though the challenges presented are great, the EU has the unique ability to provide a leadership role by standardising a high level of service agreements throughout the Member States, by facilitating the continuing education of practitioners and policymakers, and by creating equalities strategies that put the needs of transgender and transsexual people at the forefront.

[69] To Prof. Whittle in conversation in October 2007 at the UNISON Road Show, Manchester.

Glossary of terms

Trans Person/People/Man/Woman: inclusive terms embracing those who cross (or have crossed) the conventional boundaries of gender; in clothing; in presenting themselves; even as far as having multiple surgical procedures to be fully bodily reassigned in their preferred gender role.

Transvestite people: Transvestite people (TVs) enjoy wearing the clothing of the 'opposite' sex for short periods of time. They are generally men who started cross dressing as they entered puberty. Their sense of female identification can range from being very strong and indeed, their 'real' selves, to being only half of their identity – they may identify for example as 'bi-gendered'. As they get older, some may decide that they are in fact transsexual and will proceed to living permanently in their new gender role, choosing to take opposite sex hormone therapies and may even choose to have gender reassignment (sex change) surgeries. Others are happy to continue 'dressing' part-time for the rest of their lives.

Transsexual people: Transsexual people generally identify as a member of the opposite sex from a very early age. When young, they may describe it as 'being born in the wrong body'. At some time in their life, depending upon their personal and social circumstances, their family support, and their own determination, they will seek medical advice, and many will be diagnosed as being transsexual. With medical support, they will start hormone therapies and begin living permanently in their preferred gender role. Most will proceed to have some, if not all, gender reassignment surgeries. Those who change from being female to male are referred to as trans men i.e. they are now men with a transsexual history. Similarly those who change from male to female are referred to as trans women. Gender reassignment surgeries vary depending upon birth sex.

Transgender people: Transgender is used as a very broad term to include all sorts of trans people. It includes cross dressers, people who wear a mix of clothing, people with a dual or no gender identity, and transsexual people. It is also used to define a political and social community which is inclusive of transsexual people, transgender people, cross-dressers (transvestites), and other groups of 'gender-variant' people such as drag queens and kings, butch lesbians, and 'mannish' or 'passing' women. 'Transgender' has also been used to refer to all persons who express gender in ways not traditionally associated with their sex. Similarly it has also been used to refer to people who express gender in non-traditional ways, but continue to identify as the sex of birth. Now, many people who present their gender in a variety of ways which are at odds with the norm will consider themselves to be transgender. There are also those who prefer in their day to day life to permanently dress in the clothing of the opposite sex, without any medical intervention at all. Their communities may not, in many cases, know of their birth gender.

Cross dresser: transvestite; a person who wears the clothes of the opposite birth sex group.

Cross gender living: living in the gender role of the opposite anatomical sex group.

FTM: Female-to-male, most commonly used to refer to a female-to-male trans person (transsexual or transgender man). Someone who was assigned female at birth who identifies as male. A trans man.

Gender: An individual's personal sense of maleness or femaleness. It is also a social construction that allocates certain behaviours into male or female roles. These will not always be the same across history, across societies, across classes, hence we know that gender is not an entirely biological matter, rather it is influenced through society's expectations.

Gender Dysphoria: The term used by psychiatrists and psychologists to describe the condition transsexuals have – that is not feeling well or happy with their gender as assigned at birth, in terms of both their social role and their body. Gender dysphoria is not characterised by denial; for instance, female-to-male transsexuals acknowledge that their (pre-transitional) bodies are female. The fact that their anatomy does not correspond with their sense of being male (psychological sex) leads them to seek to bring the two (body and mind) into harmony. Specifically, the diagnosis states that Gender Identity Disorder is characterised by a strong and persistent cross-gender identification which 'does not arise from a desire to obtain the cultural advantages of being the other sex,' and that it should not be confused with 'simple nonconformity to stereotypical sex role behaviour.'
Many transsexual people wish for the disorder to be classified as physical rather than mental, especially in light of recent research showing the physical basis of transsexuality, but feel that until this occurs there needs to be a medical diagnosis to ensure the continued availability of treatment.

Gender Identity: A person's internal sense of being male or female. This sense of awareness affects the individual's conscious (and perhaps unconscious) cognitive processes, and in turn greatly influences his or her social interaction with others. Most non trans people take their gender identity for granted as it corresponds with their birth sex.

Gender Identity Disorder (GID): Listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) for the American Psychiatric Association (APA).

Gender Reassignment: Term used for the medical treatments including hormone therapies and surgical procedures to change a person's appearance to nearer that of the opposite birth sex group. This may also be the legal or juridical process where a person is formally 'recognised' by the State in their 'new' gender role.

Gender Reassignment Surgery (GRS): Medical term for what transsexual people often call gender-confirmation surgery: surgery to bring the primary and secondary sex characteristics of a transsexual's body into alignment with his or her internal self-perception.

Gender Recognition: A process whereby a transsexual person's preferred gender is recognised in law, or the achievement of the process.

Gender Role: How a person expresses himself or herself in terms of traits commonly associated with masculinity and femininity. Gender role is largely a social construct, since every society has different ideas about what sort of dress or behaviour is 'appropriate' for males or females. However,

children do appear to have an instinctive idea of male and female, and typically prefer to model their behaviour after that of the sex they identify with.

Gender variant: A term used for anyone whose gender 'varies' from normative gender identity and roles of the gender assigned at birth.

LGBT: Acronym for lesbian, gay, bisexual and transgender.

MTF: Male-to-female, most commonly used to refer to a male-to-female trans person (transsexual or transgender woman). Someone who was assigned male at birth who identifies as female; a trans woman.

Transition: The process of beginning to live full-time as the opposite sex and changing the body, through hormones and surgery.

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Appendix: The Survey Questions Relevant to This Report

Trans Europe Survey

English	Other

Section 1

My country of residence is

Austria

Belgium

Bulgaria

Cyprus

Czech Republic

Denmark

Estonia

Finland

France

Germany

Greece

Hungary

Ireland

Italy

Latvia

Lithuania

Luxembourg

Malta

Netherlands

Poland

Portugal

Romania

Slovakia

Slovenia

Spain

Sweden

United Kingdom

I identify as

In what country were you born?

Were your parents born in that country?

yes, both

yes, father but not mother

yes, mother but not father

no, neither

My age, in years, is:

18 -21

21-25

26-30

31-35

36-40

41-45

46-50

51-55

56-60

61-65

66-70

71-75

75 +

Do you consider yourself to have a disability?

Yes

No

If you do consider yourself to have a disability please describe

I am

Gainfully employed full time

Gainfully employed part time

Unemployed

Full-time student

Retired

Sick/ unable to work

My work is falls in the following category:

I Higher professionals, administrators, managers etc.

II Lower professionals and similar jobs etc.

IIIa Routine non-manual employees, some qualification needed

IIIb Routine…no qualification

IVa Small proprietors with employees

IVb Small proprietors without employees

IVcd Self-employed farmers

V Supervisors of manual workers, low grade technicians

VI Skilled workers

VIIa Unskilled workers

VIIb Agricultural workers

My current average GROSS YEARLY (before deductions) earnings are:

In receipt of State benefits

In receipt of retirement pension

Full time student

Less than €5,000

€5000 - €10,000

€10 - €15,000

€15 – €20,000

€20 - €25,000

€25 - €30,000

€30 - €35,000

€35 - €40,000

€45 - €50,000

€55,000 - €60,000

€65,000 - €70,000

€75,000 - €80,000

More than €80,000

How would you describe your current household position or living arrangement?

Living with my parents most of the time

Living alone most of the time, away from parents and without partner

Living together with a partner without marriage

Living with a husband or wife in a marriage

Living apart from a partner, but regularly exchanging visits with this partner in our homes

Do you have any savings or investments?

Yes

No

If you do have any savings or investments, please describe the value

The highest educational level I have reached is:

0. Not completed primary (compulsory) education
1. Primary education (end of compulsory education)
2. Lower secondary education
3. Upper secondary education
4. Post secondary, non-tertiary education
5. First stage of tertiary education (not leading directly to an advanced research qualification)
6. Second stage of tertiary education (leading to an advanced research qualification)

I currently present myself in my preferred gender:

At home only

Socially only

At work only

In the home and socially

Permanently at all times

If you ARE NOT yet living permanently in your acquired gender, do you intend to do so in the future?

If you ARE living permanently in your acquired gender, please ignore this question and go to question no…

Yes

No

If you are not yet living in your preferred gender, what is preventing you? Tick all that apply

My job or workplace

My family or partner

My home or social life

I do not want to live permanently in my preferred gender

I prefer to have a mixed gender

I am a crossdresser and do not wish to dress other than for private, social, work (e.g if you do drag) or other special occasions

Answer only if you are now living permanently in your acquired gender: I started the process of gender reassignment

Less than 5 years ago (between 2002 and 2006)

More than 5 years ago

More than 10 years ago

More than 20 years ago

What legal documentation do you possess in your preferred gender?

Birth Certificate

Identity Card

Passport

Driving licence

How did you obtain your document changes?

Had to go to a court

Administrative process

Section 2
Healthcare

If you have not accessed trans specific healthcare as a trans person please go to Section 3

When you first talked to a doctor or psychiatrist about your transition, how did they respond?

Was informative and helpful

Wanted to help but lacked information

Did not appear to want to help

Refused to help

Have you ever been refused any treatment because a doctor or nurse did not approve of gender reassignment?

Yes

No

Don't know

Have you ever been refused, or made to wait far longer than expected, for any treatment relating to your transgender or transsexual health care, including gender reassignment, after appropriate clinical recommendation?

Yes

No

Yes and then I paid for my own treatment

No – I paid for my own treatment

Have you had any of the following procedures?

Mastectomy

Breast Augmentation

Phalloplasty

Metaiodoplasty

Vaginoplasty

Sterilisation

Electrolysis

Feminising Hormones

Masculinising Hormones

Was this between 2002 and 2007?

Yes

No

Have you been refused State insurance scheme funding for any of the following procedures?

Mastectomy

Breast Augmentation

Phalloplasty

Metaiodoplasty

Vaginoplasty

Sterilisation

Electrolysis

If you answered yes to the following question did you pay for this procedures yourself?

Yes

No

Have you ever been refused State funding for Hormones?

Yes

No

Do you feel that being trans has ever affected the way you can access routine healthcare treatment that is not related to being transsexual/transgender?

Yes

No

Do you feel that being trans adversely affects the way that you are treated by healthcare professionals?

If you answered 'yes' to either of the questions above, please describe a fairly recent example of how you have been treated differently

Have you ever experienced the following while being treated in hospital or accessing healthcare?

Tick all that apply

Treated differently in a negative way

Comments

Verbal abuse

Threatening behaviour

Physical abuse

Sexual abuse

Nothing like this happened to me

Was this from any of the following healthcare professionals? Tick all that apply

Doctor

Hospital doctor or surgeon

Nurse

Psychiatrist

Physiotherapist

Occupational therapist

Radiologist (takes X rays)

Hospital pharmacist

Other

As a young person (under the age of 21) Did you ever attempt suicide, or self harm, because of being a cross dresser, transgender/transsexual or because of other people's reactions to you being trans?

No

Once

Twice

More than twice

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